Emotional work, emotional wellbeing and professional practice: the lived experiences of women community health nurses providing palliative care in the home environment in Australia

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Emotional work, emotional wellbeing and professional practice: The lived experiences of women community health nurses providing palliative care in the home environment in Australia.

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A thesis submitted in fulfillment of the requirements for the award of the degree of Doctor of Philosophy.
School of Health and Human Sciences
December 2008
DECLARATION OF ORIGINALITY

I certify that the work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text, and that the material has not been submitted, either in whole or part, for a degree at this or any other university.

I acknowledge that I have read and understood the University’s rules, requirements, procedures and policy relating to my higher degree research award and to my thesis. I certify that I have complied with the rules, requirements, procedures and policy of the University (as they may be from time to time).

Print Name:…………………………………………………………………

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Date:………………………………………………………………………
ABSTRACT

This research set out to explore the relationship between emotional work, emotional wellbeing and professional practice of community nurses who provided palliative care to clients living at home. Three specific aims were investigated; the concept of emotional wellbeing; the relationship between emotional work, emotional wellbeing and professional practice; and the strategies utilised by the nurses that promote their emotional wellbeing.

An emancipatory framework was applied to this study. The research was epistemologically and ontologically located within a critical and feminist framework. It was believed that the chosen methodological approach was well situated to address the subjective experiences of the sixteen women community nurses who participated in this study. The participants were all registered nurses employed by New South Wales Health and were geographically located across rural and urban New South Wales, Australia. Data collection was undertaken over a fifteen-month period. The chosen methods were semi-structured interviews and reflective journaling.

The findings revealed that the concept of emotional wellbeing was complex and multifaceted. The participants associated emotional wellbeing with feeling energetically balanced or out of balance. There was a pervasive interconnectedness between emotional work, emotional wellbeing and professional practice that was influenced by multiple factors including the emotional impact of emotional work and various workplace challenges. Three main themes emerged, those being: Demanding; Rewarding; and Comfortability. Self-care was recognised as being important to the nurses and strategies to enhance their wellbeing were identified. These included healthy lifestyle choices, debriefing, self-validation, assertiveness and the need for emotional support.

It is argued that community health nurses are well positioned to critically examine their work environments and explore the issues that hinder or enhance their professional satisfaction and emotional wellbeing. The profession of nursing has traditionally promoted holistic healthcare practice in client care. Yet the holistic and humanistic care of nurses has been relegated to the margins, particularly when exploring emotional issues. Emancipatory inquiries provide valuable opportunities for researchers to address the complex issues faced by nurses as it enables nurses to speak from their hearts, thus creating transformative opportunities that have benefits for educators, nurses, the nursing profession and recipients of nursing care.
PUBLICATION IN THESIS

Background for incorporating publications into doctoral thesis
Southern Cross University supports postgraduate research students publishing their work during candidature. It demonstrates to examiners that the student’s work has been peer reviewed and that the research is deemed worthy of publication. It also maintains currency of the candidate’s work as it is completed and for students wishing to do postdoctoral work, having a publication record is essential.
(Southern Cross Graduate Research College 2008)

Statement
I hereby submit the following work to be taken into consideration in the marking of this thesis. In accordance with the definition stated above, the peer reviewed work combine to form the full body of research under investigation.
SCHOLARLY OUTPUTS DURING CANDIDATURE

Refereed Journal Publications

(Contribution: Rose 70% & Glass 30%).

(Contribution: Rose 70% & Glass 30%).

(Contribution: Rose 70% & Glass 30%).

(Contribution: Rose 70% & Glass 30%).

Under consideration


Refereed Conference Presentations


(Contribution: Rose 70% & Glass 30%).
ACKNOWLEDGEMENTS

To all of the community nurses who participated in this study I thank you for your trust, honesty and generosity of time and spirit. I hope that your shared stories, visions and insights will bring about positive change to all nurses, clients and the community.

To my supervisor Associate Professor Nel Glass, I thank you for your encouragement, support, wisdom and numerous hours of supervision. We have travelled on two research journeys and on each occasion new insights into the endless world of possibilities have been created.

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<td>CN</td>
<td>Community Nurse</td>
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<td>CNs</td>
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<td>CNC</td>
<td>Clinical Nurse Consultant</td>
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<td>CNS</td>
<td>Clinical Nurse Specialist</td>
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<td>EWB</td>
<td>Emotional wellbeing</td>
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<tr>
<td>GCN</td>
<td>Generalist Community Nurse</td>
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<tr>
<td>GP</td>
<td>General Medical Practitioner</td>
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<td>Faux pas</td>
<td>An embarrassing moment that breaks a social convention of some kind</td>
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<td>iPod</td>
<td>© Apple Computer Pty. Ltd. Utilised for interviews</td>
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<tr>
<td>Kit</td>
<td>A pack containing relevant policy procedures and equipment necessary for the post-mortem management of a deceased person</td>
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<td>NUM</td>
<td>Nurse Unit Manager</td>
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<tr>
<td>NSW</td>
<td>New South Wales, a state in Australia</td>
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<td>PC</td>
<td>Palliative care</td>
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<td>PCA</td>
<td>Palliative Care Australia</td>
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<tr>
<td>PCN</td>
<td>Palliative Care Nurse</td>
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<tr>
<td>PCSN</td>
<td>Palliative Care Specialist Nurse</td>
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<td>PP</td>
<td>Professional practice</td>
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<td>Professional Practice</td>
<td>The palliative care nursing practice provided by the generalist community nurses</td>
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<td>RN</td>
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Chapter One

Introducing the research
Introductory words

This research explores the relationship between emotional work, emotional wellbeing and the professional practice of practicing (generalist) community health nurses (CHNs) providing palliative care. This research focus was chosen due to my sustained interest in emotional health and more specifically, the emotional health of registered nurses and the relationship it holds with their professional practice. Whilst I would argue strongly that emotional wellbeing is a significant issue for all health care professionals however, for the purpose of this research, the focus is specifically on community health nurses.

Within this introductory chapter I will outline the cornerstone development of the research topic and my inherent professional stance that acknowledges my influence on the project and the framework that supports its creation. I will then outline how I narrowed the motivations for the project and developed the specific research focus. Methodological considerations are then introduced followed by an outline of the thesis presentation and styles used herein. The chapter concludes with an outline for each chapter.

I will begin with a discussion of the foundational development of the project taking into account that this research has been as much a personal journey as it has been professional and therefore I will commence by introducing you to the emerging project.

The cornerstone development of the research project

Throughout my nursing career I have developed and maintained a strong interest in the concept of emotional wellbeing and in particular, the health of registered nurses. It is my belief that nurses’ emotional wellbeing is integral to personal and professional satisfaction.

New beginnings

My interest in emotional wellbeing developed after commencing my undergraduate degree in 1998, during which time I underwent an acute period of raised self-awareness accompanying a significant emotional and spiritual transformation. My specific interest on emotional wellbeing developed as a result of my own life changing experiences and gained further momentum as my university education expanded and my world of knowledge became expansive. I developed a stronger awareness of the relationship between
intellectual knowledge and the issues related to socialisation and socio-political influences. I was able to identify more clearly the injustices that had held power over my life and the life of others as women and nurses.

With increasing insight into the emotional impact of the challenges I had faced, I became increasingly conscious of the political and social agendas that had influenced those events. Over time, I was to experience multiple states of personal empowerment leading to the development of new choices that were increasingly liberating and life changing. In effect I had been emancipated.

My thirst for knowledge continued, wanting to learn and understand more about the impact of marginalisation and oppression and the impact that this had on women’s lives. I sought to make sense of all that I did not understand, seeking explanations and answers. I wanted to stand under a fountain of knowledge and absorb it like a sponge, infinitum.

However, I was mindful that empowerment was not a linear state, moreover, it was in fact states of being (Glass, 1998). Experiencing states of empowerment did not divert myself from the struggles I encountered with low self-esteem and a self-concept. I had found myself in situations, both personally and professionally, that required me to draw deeply upon my internal resources in order to deal with emotional challenges I faced. Such a process involved various states of emotional adaptability as my emotions were constantly changing dependent on the situation and my ability to manage. I likened my varied emotions metaphorically to autumn leaves, whereas at times I felt windswept and at other times grounded. I journalled the following poem:

Autumn leaves  
Leaves in the wind  
Up in the clouds  
Conveyed to new places  
Unable to ground

The turbulence stops  
Calm, cushions their fall  
Leaves journeying down  
Grounded once more.
As the years progressed, my undergraduate education complete and my full-time nursing career embarked upon, it was a critical time that led down an ongoing complex pathway of reflection and introspection. I began to examine my life journey, my beliefs, practices and achievements. What remained a priority was how I cared for myself. It was the beginning of a new journey that opened doors to valuable insights, particularly into my own state of emotional wellbeing.

During that period of transition, I became centred on my own health and the relationship it held to my professional practice. I was also acutely aware of my colleagues’ states of emotional health. I realised that whilst I was recognising my own need for support, I noted that even the most experienced of my colleagues became emotionally wounded at times due to the nature of their clinical practice. More importantly, I became conscious that some colleagues felt able to reach out for support whilst others did not.

This inconsistency raised a dialectical tension, as I found myself in a position of supporting others who were emotionally troubled, whilst at times I was simultaneously reaching out for support. These professional encounters were the impetus for the development of my research interest in emotional wellbeing. I had a strong desire to explore and gain a greater understanding of the embedded complex issues and most importantly, to gain insight into the relationship between emotional wellbeing and the professional practice of nurses.

**Emotional wellbeing**

Without doubt my focus on emotional wellbeing stems from what I believe to be an interconnection between the personal/professional interface of nursing and its relationship to professional practice. Therefore an aim of this study is to develop an increased understanding on these factors and expanding upon my Honours research on emotional wellbeing (Rose, 2002).

My honours research explored the relationship between emotional wellbeing and professional practice of women community mental health nurses. In this research it was found that whilst emotional wellbeing was a nebulous notion it held a strong relationship with the nurses’ professional practice (Rose & Glass, 2005, 2006a). I was strongly moved by the women participants involved in the study, particularly their overall passion for their
clients, their work and their own states of emotional wellbeing. It became quite evident that a dearth of literature, specific to registered nurses and particularly emotional wellbeing, existed.

My motivations were therefore fuelled by a belief that exploring the emotional wellbeing of nurses is paramount to a comprehensive understanding of rapid burnout and attrition in the contemporary nursing workforce. Whilst it could be strongly argued that the study of emotional wellbeing and professional practice could be applied to any nursing disciplines, it was community health nurses that held a strong interest for me.

**Researching community health nurses**

The reason I have chosen community health nurses is primarily related to my clinical practice as a community health nurse and most importantly, the professional situations I have encountered whilst working in the discipline. Being mindful of my own emotional health has enhanced my ability to recognise the impact that emotional work has had upon myself. However, this has also helped me to identify the impact it has had on my colleagues. The new insights have proven beneficial in that they have provided me with opportunities to address issues that have arisen out of my clinical practice and importantly, created opportunities for my colleagues to address their emotional needs as practitioners.

**Choosing community nurses providing palliative care**

I maintain a meaningful connection with the clinical discipline within community health and in particular, a deep commitment to the philosophy of palliative care. However there were times when palliative care provision had drawn deeply upon my emotional resources and my lack of attention to addressing those needs had resulted in impaired wellbeing. Maintaining a balance between the emotional aspects associated with palliative care provision and my emotional wellbeing remains a critical issue for me, personally and professionally. Hence the underlying reason for my continued research interest can be based on my professional experiences associated with palliative care and my desire to develop a deeper understanding of the wellbeing/practice nexus. I strongly believe that expanding our understanding can create new opportunities for positive change for all nurses and recipients of care.
Palliative care is holistic, patient and family centred care provided for dying people and their families. Palliative care services acknowledge dying as a physical, psychological, social, spiritual and cultural process that is experienced uniquely by each person and family (NSW Health, 2001, p.3).

The above statement was drawn from the larger definition of palliative care as outlined in the NSW Palliative Care Framework (NSW Health, 2001), however it is not my intention to discuss palliative care in length at this time as it will be addressed more extensively throughout the body of this thesis. The above definition is aimed to highlight the holistic philosophy that underpins palliative care, an approach that has been central to my clinical nursing practice.

I begin by declaring that I have felt drawn to palliative care nursing for many years - there is something uniquely special about supporting a client, carers, family and significant others holistically through such a challenging and distressing time. When a client reaches a point in their illness where cure is no longer possible, the philosophy of palliative care creates new possibilities for clients and their loved ones, and involves support during life and following the client’s death. Health professionals including primary health care providers have a responsibility to provide support and care that optimise a client’s potential, promoting quality of life and creating the hope needed during such a critical time.

Terminal care has been a core component of nursing across many of its disciplines and is provided in various settings from inpatient acute care and palliative care services to residential aged care facilities and community home-based environments. However when it comes to nurse visibility, it has traditionally been the palliative care specialist service providers that have been recognised for their valuable role in palliative care provision, leaving other service providers for example, in the case of community health nurses, left feeling less visible.

For community health nurses speaking openly about how they feel when caring for people with a terminal illness or, more specifically, sharing their feelings related to death and dying issues, these have not generally been discussed outside of their peer nursing group. Furthermore, I would argue that for many community health nurses, the discussions remain superficial and their deeper feelings repressed. These issues are significantly related to
this current study, as my early years in nursing were affected by the many challenges I encountered with palliative care provision, and were significant to my career and subsequent research endeavours.

There were occasions during my undergraduate student days that I found myself in situations that had a major affect on my wellbeing, finding particularly that my involvement with terminal clients and their significant others, were draining physically, psychologically, emotionally and spiritually. The following story highlights significant issues in my terminal care nursing, how my consciousness was raised and the foundations were laid for my journey to explore the philosophy of palliative care and to address the critical issues related to the emotional wellbeing of the nurses. The story begins on a busy medical ward where, as a student nurse, I was feeling like a fish out of water.

The story is told in three parts. Part One entitled ‘A fish out of water’ will provide a clinical background. Part Two entitled ‘The faux pas’ will tell of an encounter I had with the patient and Part Three entitled ‘Reflections’ reveals the issues that arose following the patient’s death.

A fish out of water

Feeling like a fish out of water but filled with enough enthusiasm for all to share, I was ready to absorb the learning experience. I was given a patient allocation under the supervision of a Registered Nurse (RN). The patient was in the terminal phase of her life. As I made my way toward the room I observed the chaos of nurses and people rushing about. I was given rapid instructions from a Medical Officer and informed that the patient was not expected to live long.

As a mature age woman I was familiar with death and dying on a personal level however, as a student nurse, I admitted to feeling quite unprepared for this clinical situation, leaving my internal mechanisms quietly anxious. My mind raced with self talk, questions such as ‘what to do?’, ‘how to do it?’, ‘what do I say?’ and ‘will I do it well enough?’ conversations that raised more questions. The Clinical Educator was not to be found.
The faux pas

With the family gathered closely around their loved one, I went into intuitive mode, responding to their nursing and emotional needs as best I knew how, blending my nursing knowledge and my life experiences. With the initial necessities attended, I took the next opportunity to phone the Clinical Educator again to request her attendance for advice. Whilst I acknowledged feeling moderately overwhelmed and unprepared to address the death and dying issues related to this client’s care, it was equally the uncertainty related to the policies and procedures of the institution, all the legalities and process of which I was unfamiliar that concerned me.

What was the correct procedure immediately following the death of a patient on the ward? I needed to feel fully prepared for all possibilities. Perhaps it was the sudden urgency of the situation that created such feelings and a raised awareness of the stress that the patient and family were clearly experiencing.

Once the patient was settled in the room and had been seen by the doctor, I was to replace her oxygen mask. I proceeded to inform the patient quietly that I was going to ‘pop on’ a different oxygen mask to assist her with her breathing. In my nervous haste, the swift exchange of masks saw the new mask pop off, separating from the tubing whilst still in my hand, creating a loud bang that resulted in a burst of laughter from the patient. My unintentional act had resulted in a humorous shift in what was clearly a tense environment.

Subsequently the ‘space’ became infused with warmth that lingered, enabling a focus on comfort and loving care involving all family present. The ‘faux pas’ had unintentionally created a strange connectedness between the patient, family and myself.

Soon after the patient died. I then found myself struggling with the events related to the dynamics that followed her death. I had retrieved the ‘kit’ and appropriate paper work that was necessary following the death of a patient and, accompanied by an RN who was also unfamiliar with the organisational procedures, had commenced laying out the patient. We had begun washing the patient when two RNs entered the room to take over and send us on a meal break. That upset me very much as I was committed to completing the job I had started and learning from the experience simultaneously. How could I possibly eat anyway! Didn’t anyone care how I felt! My objections were not heard.
I had taken the time with her daughter to select a gown to put on after her mother’s wash. It was white with red roses, a beautiful choice. I had pointed it out to the nurses before I stepped into the background to leave the room. I was surprised with the casual chatter exchanged over the woman as they worked diligently. It felt surreal.

I was left feeling emotionally negated after the events of that day. Yet to the experienced nurses, it was all a part of the routine and time was of the essence in that busy ward. I felt disappointed and extremely angry. No one spoke of her death, nor had anyone asked me how I felt, given I had spent most of my shift with her and supporting her family.

**Reflections**

That incident had turned out to be a defining moment in my nursing career and it was critical for me to reflect on the situation. Subsequently I journalled my thoughts and feelings regarding the day, in my endeavour to make meaning to the issues that had impacted upon me so significantly.

There were many questions raised such as: Were the actions and responses of the staff regarding their professional distance a coping strategy? Was the ward so busy that the staff were not able to address their own and colleagues' feelings? Was it considered unacceptable for nurses to show emotion related to their patients? And how do the nurses address their own emotional needs when confronted with emotional challenges in their workplace? Do the nurses perceive their work with death and dying as emotional work?

The story created more questions than answers and was the impetus for further inquiry. There are many people within our community, our hospitals and aged care facilities that will be on their final life passage, some supported and others not. It is important that the people who provide care for such a vulnerable community must also be supported.

**Narrowing the motivations for the project**

Whilst many people require hospitalisation and institutional care at end of life, there remains a broad community base that are supported by community health teams to live and die at home. Community health nurses play a significant role in such care. Remaining in the home environment can enable community clients to maximise their quality of life in a
way that can promote independence and provide opportunities for empowerment, hope and healing.

Historically, care provided by hospice staff and palliative care specialist nurses has been well recognised. However the clinical practice of other providers such as community health nurses has been given less attention. The provision of palliative care remains the role of many health care professionals who are incorporated within a team of multidisciplinary health care staff who work collaboratively with the client, their family and significant others. It is the community health nurses who undertake case management of palliative clients who are adequately supported to live in the community, calling upon the palliative care specialist team in a consultative capacity. Palliative care providers such as community health nurses, who have a substantive clinical role other than palliative care, are said to provide palliation under the definition of a ‘palliative approach’.

According to Palliative Care Australia, a palliative approach is:

- an approach linked to palliative care that is used by primary care services and practitioners to improve the quality of life for individuals with a life limiting illness, their caregiver/s and family. The palliative approach incorporates a concern for the holistic needs of patients and caregiver/s that is reflected in assessment and in the primary treatment of pain and in the provision of physical, psychological, social and spiritual care... it provides a focus on active comfort-focused care and a positive approach to reducing suffering and promoting understanding of loss and bereavement in the wider community (Palliative Care Australia 2005, p.11).

The definition of the ‘palliative approach’ was prompted due to the call upon palliative care specialist services to be involved with a broader range of progressive and terminal illnesses (Kristjansen, 2005). Thus a definition of a palliative approach was created for providers who work outside of specialist palliative practice. The primary goal of the services providing a ‘palliative approach’ is to “improve the ill person’s level of comfort and level of function” (Kristjansen 2005, p.190).

In my role as a community health nurse involved in palliative care provision, I have been deeply moved by the humanness that can be revealed by clients who are confronted by life threatening illness. There have been many times of mixed emotions for clients, and their
significant others. The relationships that can develop between nurse, client and significant others can be extremely meaningful. For me, palliative care exemplifies holism in nursing practice and I consider palliative care as being one of the most privileging roles that I have undertaken in my nursing career.

Whilst the term ‘privilege’ may hold various meanings including ‘benefits, advantages and rights’, applied in the context of my palliative care role, it relates to the feelings of pleasure and joy that can result from the meaningful relationships that I have encountered over the years. The relationships have encompassed elements of trust, safety and respect and have been dependent on the client’s desire and/or willingness to let me psychologically and emotionally into their inner world. Such encounters can be as challenging for the client as they have been, at times, for myself as the visiting community health nurse.

With any nurse/client relationship, the interactions have the potential to create opportunities for improved outcomes, however, the outcomes can be dependent on the nurse’s capacity and willingness to feel comfortable with and accept being ‘let in’ to the client’s world. Community health nurses who have experienced trauma related to death and dying in a personal or professional capacity, may feel reluctant to develop a heart connection with their clients and significant others and subsequently, the care will remain task orientated. However, I clinically engage on a level where on many occasions I have felt ‘let in’ to a client’s inner world, where the depth of sharing has become in-depth and a sense of feeling privileged has developed.

Every client situation is unique and whilst distinctive challenges arise, building workable relationships are central to the provision quality holistic care. The nurse/client relationships are generally established within a short time, are time limited and always context dependent. The following is a poem I had written and is reflective of my thoughts related to my clinical practice and is expressive of feeling privileged as a provider of palliative care:

A nursing privilege
I tend your care, as nurses do
Dress your wounds, bathe you too.
Ensure your comfort, relieve your pain
Caring for the physical domains.
But you are dying, your life is short
My heart is with you, my every thought.
You are a mother, father, son,
A daughter, grandma, loved grandson.

I bear in mind, as I provide you care
That you could be my relative lying there.
Your needs are many, beyond physical realms
And I attempt to stay ‘present’ and listen well.

You hardly know me, nor I you
Yet you shared stories with me from a lifetime view.
I feel very privileged to have been let in
Sharing with me what you felt deep within.

You trusted me, felt safe to speak
Then you closed your eyes, your body weak
You have moved on now, but in body alone,
Your memories etched in my heart like stone.

I frequently feel gifted in my palliative care practice especially when I am able to identify that my contribution has in some way enabled, empowered, comforted and/or supported a client and/or family through their experience. In other words, when I feel that I have made a difference. I consider being a provider of palliative care as involving emotional work and it has the potential to impact upon my emotional wellbeing. I have recognised occasions when I have failed to address my own health, placing it second to the needs of others. The traditional nursing culture encourages nurses to focus on caring for others, yet we must ask ourselves how we can effectively care for others if we do not recognise the need to actively care for ourselves. I strongly concur with the words of Birx (2003) who asserted, ‘healing yourself is an essential foundation for healing others’ (p.46).

Specific research focus

As I explored the topic related to emotional wellbeing further, the nursing scholarship tended to focus its attention more frequently on issues related to client care, family members and/or significant others. What was noticeable was the abundance of literature
related to nurses and stress, however less evident was the specific focus on nurses’ emotional wellbeing. This again reinforced my belief that more research was necessary if health professionals were to gain increased knowledge in this area.

In addition I strongly believe that nursing work involves emotional work, that emotional work impacts on one’s emotional wellbeing and emotional wellbeing is integrally linked to professional practice. This claim is significant to the future of nurses, nursing practice and more broadly to the nursing profession. It is from this premise that I undertake further investigation into the concept or notion of emotional wellbeing, moving the central focus from patient/client wellbeing, to nurse/healer wellbeing.

More specifically, this research sets out to holistically explore the relationship between emotional wellbeing and professional practice of (generalist) community health nurses (CHNs) providing palliative care to clients in their home environment. I would now like to expand on my interest in emotional wellbeing.

This study will bring to light the existence of individual stories, as seen through each participant’s unique lens and narrated by myself, the researcher, and as researcher/participant. This project was intentionally designed to highlight individual experiences related to the nurses’ emotional wellbeing and was particularly focused on a process that valued diversity and difference and drew together knowledge and wisdom for the benefit of all nurses within the profession.

Based on my belief that nurses who provide palliative care engage daily in a professional practice that involves emotional work, I have focused this study on exploring the relationship between emotional work, emotional wellbeing and professional practice. The research question being asked is:

What are the lived experiences of women community health nurses providing palliative care services to clients in their home environment in relationship to their emotional work, emotional wellbeing and professional practice?

The aims of the study are to:

- Explore the meaning of emotional work.
- Explore the meaning of emotional wellbeing.
Explore if emotional work and emotional wellbeing are components of community health palliative care practice.

Focus on the lived experiences of community health nurses providing palliative care.

More specifically to explore with each of the participants:

- The concept of emotional work.
- The relationship between emotional work, emotional wellbeing and professional practice.
- The strategies utilised by the nurses that promote their emotional wellbeing.

The above research questions were purposefully framed in critical social science and feminism, a methodological process that sets out to draw together the epistemological/ontological links necessary to acknowledge and validate the multiple voice/s and experiences of the women participants who took part in this research. What follows is a further explanation of the research methodology.

Methodological considerations

In undertaking this research I needed to ensure that an appropriate methodological framework was applied. It was essential that the design be aligned with my position as a feminist and subsequently a critical feminist theoretical framework will be applied. This approach supports my belief and the belief of others, that women and nurses are subjected to various levels oppression and/or minimisation as a result of gender and the health care system (Glass, 2000; Glass & Walter, 1998; Roberts, 2000, 2006).

Furthermore, feminist scholars have contended that the silencing of women is a pervasive phenomenon (Glass & Davis, 1998; Walter, 2003) further perpetuating the oppression of women. It is my intention that by applying a feminist process that the multiplicity of voice/s and the individual experiences of the community health nurses will be heard, acknowledged and validated. According to Glass (2000) “applying feminist theory in action can result in transforming oppressive experiences considerably… which can continue to improve contemporary nursing” (p.365).
It is also my belief that the current health care system fails to adequately recognise, value and/or validate its most valuable asset ‘the nurse’. The nursing profession is bound by financial restraints plagued with staff shortages. As a result, the impact of additional stress and strain is experienced across many health sectors yet critically highlights the need for nurses to be pro-active and care for their own state of health and wellbeing.

However, “the first principle is to reflect on self and one’s own woundedness and healing” (Hall, 1997a p.12). It is through this process that stress-related illness and/or burnout may be minimised and/or avoided and a greater sense of personal and professional fulfilment and emotional wellbeing be achieved.

It is anticipated that by giving voice to the women nurse participants in this research, that their lived experiences in professional practice will be revealed and that benefits to their emotional wellbeing will be realised. In addition, to the emancipatory intent for the participants, the researcher hopes that benefits for all nurses and the recipients of care will be realised.

**Thesis style and presentation**

**Thesis incorporating publications**

The writing style chosen is ‘thesis incorporating publications’. I was first introduced to the notion of this style quite informally during a social function when a doctoral student outside of nursing was sharing her research process. Writing publications throughout the research development was appealing to me, as it provided opportunities for early dissemination of the findings whilst simultaneously developing publishing skills in pursuit of an academic path.

When I set out on this journey there were limited resources to guide the thesis style. I accessed the doctoral work of other scholars in order to gain an understanding of size and quality of the accredited research. I searched other libraries electronically and in person and was unable to source any nurse scholars who had undertaken their thesis writing in this way. After careful deliberation and consideration with my research supervisor, the decision was made to aim towards publishing three to five internationally refereed journal
articles, in addition to a body of work that is not addressed comprehensively in the publications.

The other issue worthy of consideration was the associated risk with undertaking this style of writing. With many nursing scholars unfamiliar with this technique, there remained a risk that the non-traditional style may prove disadvantageous in terms of final assessment. However, it was critical to balance the non-traditional approach to the value of publishing components of the study. Whilst many researchers choose to publish following completion of their doctoral studies, an approach that encourages the research findings to be disseminated at the earliest opportunity is congruent with academic pursuits and extremely beneficial to contemporary nursing practice, as it aims to address the increasing demand for evidenced-based practice that has been a key focus across all nursing disciplines in recent years. Accordingly, the inclusion of articles co-authored with my research supervisor, Associate Professor Nel Glass, and subsequently published during the course of this project will be incorporated into the associated chapters.

**Formatting and font style**

The main text is written in the font ‘Arial’ and is applied throughout the body of the thesis. In places that I have inserted an excerpt from my reflective journal or written a poem, I have used the font:

‘*Trebuchet MS* with a size 12 font and it will appear in italics like this and at times indented with a left margin like this.

Where I have cited the participant’s voice/s throughout the thesis, I have used the font:

‘*Chalkboard* in a size 12 font, which looks like this and will be indented with a left margin like this.

**Chapter outlines**

I will now summarise the following chapters that form this thesis, the formatting and font style/s that signify the various voices within the thesis, and a chapter summary.
Chapter two – Literature review: The current discourse will provide a comprehensive review of the literature surrounding the focus of this study. This chapter will introduce four sections: Section one will present the initial research proposal that was submitted in October 2004; Section two will increase the focus by presenting the publication Rose, J., and Glass, N. (2006b) Nurses and palliation in the community: The current discourse *International Journal of Palliative Nursing, 12*(12), 588-594 that reviewed the literature to 2006; Section three will review the literature that was not addressed due to the word limitation of the publication; Section four will then provide a review of the current trends that are relevant to this study, with a focus of research published between 2006-2008.

Chapter three – Methodology: An emancipatory inquiry outlines the methodological framework and the design chosen for this study, including discussions on the ethical considerations and research methods. This chapter includes the internationally refereed journal publication: Rose, J., and Glass, N. (2008). The importance of emancipatory research to contemporary nursing practice Contemporary Nurse 29(1), 8-22.

Chapter four – Research findings: Creating visibility discusses the process of data analysis and then introduces the women nurse participants. A critical analysis of the findings forms the latter part of this chapter and focuses on answering the research question:

What are the lived experiences of women community health nurses providing palliative care services to clients in their home environment in relationship to their emotional work, emotional wellbeing and professional practice?

This chapter also includes three co-authored articles, one to represent each of the three research aims. One manuscript is under consideration with the internationally refereed journal, Colleague. The second article was accepted for publication in November 2008 and the article details are Rose, J., & Glass, N. The relationship between emotional work, emotional wellbeing and professional practice: An emancipatory inquiry. *Journal of Clinical Nursing*. The third article: accepted for publication in July 2008 is at ‘proof ready’ stage and the article details are Rose, J., & Glass, N. (2008a). Enhancing emotional well-being through self-care: The experiences of community health nurses in Australia. *Holistic Nursing Practice, 22*(6), 335-346. This article is presented within this chapter.
Chapter five – Conclusion: Reflections, insights and implications complete the research process and reflects upon the journey of the women participants. This chapter also explores the value and significance of the findings by reviewing the aims and addressing the research validity in relation to the project. Finally, recommendations are offered that are considered significant to the future of nurses and nursing as a profession.

Summary

This chapter has acquainted you with my research project. I have outlined the study, addressing its foundational development, and the professional commitments and influences on the project. I have addressed the motivations and ideas that formulated its progression and revealed the specific research focus. As I believe this chapter has been representative of my commitment to nursing and my involvement in clinical nursing practice, it has placed me within, not separate to this research process. I have concluded this chapter with a brief discussion of thesis and presentation style and outlines for each subsequent chapter.
Chapter Two

Literature review:

The current discourse
Chapter overview

Having provided insights into the development of this research in Chapter One, this chapter will review the relevant literature that has informed this study. The literature discussed are inclusive of research and non-research scholarship incorporating both Australian and International literature. It was intentional to explore a broad spectrum of philosophical standpoints that may enhance the depth of understanding related to the topic under study. This chapter will be presented in four sections namely: Section One - Foundational development of the research; Section Two - Increasing the focus: A published literature review; Section Three - Contemporary literature not previously addressed comprehensively; and Section Four - Current trends 2005-2008.

Section One will present the initial research proposal that was submitted in October 2004. Section Two will increase the focus by presenting the publication entitled: ‘Nurses and palliation in the community: The current discourse’ that reviewed the literature up to 2006. Section Three will review the literature that was not addressed due to the word limitation of the publication. Section Four will then provide a review of the current trends that are relevant to this study with a focus of research published between 2006-2008. I will begin with an introduction leading into Section One.

Introduction

Having worked as a generalist community nurse for some years, I have held the belief that my professional role has involved a high degree of emotional work. This is particularly true of my involvement with the provision of palliative care (PC) to clients and their families. This is not to presume that my feelings, experiences and/or perceptions are those shared by other nurses who undertake similar clinical roles. The position that I take has been informed by nursing experience/s, observation/s and professional involvement in palliative care within a variety of clinical settings.

The relationship between emotions and nursing has held a longstanding affiliation. Emotional engagement with clients remains intrinsically linked within the process of health and healing, although some nurses could argue that emotional investment is not significantly related to outcomes. Moreover, I believe that the degree of engagement or disengagement, by nurses providing care, requires a philosophical approach that
incorporates balancing the many physical, psychological and emotional aspects of one’s self in order to meet the challenges that exist in any given nursing situation. Therefore maintaining a primary focus on positive client outcomes requires diligence on behalf of the nurse and the capacity for self-awareness.

With this said, it is important to acknowledge that community nurses work in settings that are hidden from view of other professional health care workers. The nurses’ and clients’ emotional status could be acknowledged as fluid, unique and dynamic and therefore open to change at any given time. However, nurses cannot escape the explicit interrelationship between interpersonal and intrapersonal dialogue that are intrinsically linked to the nurse’s professional role. It is the unique sense of self, knowledge, skills and the capacity to provide optimal care that informs nursing practice.

Humanness can be regarded as a web of interconnectedness between one’s physical, psychological, emotional and spiritual self. A key challenge for many nurses working in community nursing, and more specifically palliative care practice, is their balance of these aspects of self. In order to create an inner sense of peace and obtain/retain personal and professional satisfaction, a sense of wellbeing is required. As the literature unfolds within this chapter, various aspects related to generalist community nursing and palliative care provision will be revealed. I will begin by introducing Section One.

Section One

Foundational development of the research

During the early stages of this study, a literature review was undertaken to provide background knowledge that would inform the project. I believe that the early literature review, whilst very limited, acted as a foundation for the comprehensive review that followed. I include this with some reservation as I found the re-reading challenging. This is especially the case as I am now critiquing the earlier literature through a more experienced lens and I am resisting the urge to omit this from the Chapter. However with that said, I regard its inclusion as important whilst it stands to identify the beginning of my literature searches. This research proposal is included verbatim, apart from updating the referencing style to uniformingly conform with the thesis in totality. Accordingly, I now introduce the original review that informed the research proposal in October 2004.
Relevant background: Research proposal, October 2004

There remains a longstanding acceptance of the significant relationship between emotions and nursing. Nursing involves emotional work. As many scholars have conferred, caregivers are not void of feelings within the process of care delivery (Birx, 2003; Hall, 1997a, 1997b; Thorpe & Barsky 2001; Tishelman, et al., 2004; Vachon, 2001, 2003). However, the majority of studies have focused on the care and treatment of the patient as opposed to the emotional wellbeing of the nurse. It is clearly evident that nurses providing palliative care are frequently exposed to difficult and often challenging situations, resulting in emotional strain (Odling, Norberg, & Danielson, 2002; Skilbeck & Payne, 2003; Vachon, 2001, 2003).

It was evident in the literature that occupational stress is a reality for many nurses, with Farrington suggesting that “the severity and impact is on the increase” (1995, p.577). Although potential sources of stress were identified (Farrington, 1995, p.576; Hopkinson et al., 1998, p.711;), it could be argued that nurses who practice in emotionally demanding roles such as palliative care, emergency nursing or mental health, may be at greater risk of occupational stress and burnout. Research undertaken by Fagin, Brown, Bartlett, Leary and Carson with community mental health nurses, reported a ratio of 1:2 as being “seriously emotionally drained” (1995, p. 351) as a result of their work. Moreover, there appeared a seemingly pragmatic acceptance of the relationship between work and stress (Hopkinson et al., 1998, p.712). However, Birx (2003) declared that the interventions that nurses perform with their patients also offer benefits for the nurse. She argued that extending a healing hand to a patient and being fully present throughout the encounter can be both a learning and healing experience for the nurse (Birx, 2003).

In an effort to explore and investigate further the relationship between nurses’ emotional wellbeing and professional practice, I undertook a research project for my Bachelor of Nursing (Honours) degree. The findings revealed that the notion of emotional wellbeing was complex yet nebulous (Rose, 2002). For the women, emotional wellbeing encompassed many facets to their ways of being and those feelings were expressed both explicitly and, at times, implicitly throughout the interview process. Critically, the link between the nurse’s emotional wellbeing and professional practice was articulated strongly. The research revealed quite a complexity to the notion of emotional wellbeing for the participants. What became evident was that wellbeing was a fluid phenomenon in
which the women recognised as involving many and various components (Rose, 2002). Moreover, the study promoted a raised sense of self-awareness in relation to the nurses’ emotional wellbeing and the impact that workplace practice had on their sense of self, both personally and professionally.

That notwithstanding, the concept of emotional wellbeing and its significance to nurses remain clearly deficient within nursing scholarship. However, valuable contributions should be acknowledged (Birx, 2003; Sawatzky, 1998; Tully, 2004; Walter, 2003). Workplace practice issues such as burnout have been explored (Barling, 2001; Omdahl & O'Donnell, 1999; Taylor & Barling, 2002) and more specifically stress, violence and bullying (Farrell, 1999; Farrell & Bobrowski, 2003; Glass, 1997; Glass, 2003a; Glass, 2003b; Jackson, Clare & Mannix, 2002;). The above literature all highlight ongoing issues inherent within contemporary nursing practice. It could be argued that the increased pressure and stress being placed on nurses today further contributes to their state of vulnerability. Such repeated exposure is significant, as it has the potential to disturb, alter or harm the emotional health and wellbeing of the nurse and hence impede personal and professional growth. These factors make it essential to address the needs of nurses in relation to caring for themselves. As Birx stated, “this is not selfish thinking - healing yourself is an essential foundation for healing others” (2003, p.46)

Arguably, occupational stress remains not only harmful to oneself but also potentially harmful to the recipients of nursing care. Authors such as O'Connor, (2002); Gold and Thornton (2001), and Winter and Swanson (2000) all speak of the professional demands placed on nurses today and clearly express the need for nurses to focus on self-healing strategies. Healing strategies implemented for self-care assist nurses to achieve a sense of job satisfaction, however the nurses must firstly acknowledge the emotional impact they bare and secondly, identify strategies that would enhance their personal and professional growth (Rose, 2002).

In regard to nursing stress, valuable contributions were made by Hall (1997b). Her scholarly article entitled Nursing stress: applying the wisdom of the wounded healer, emphasised that being a healer involves “demands, difficulties, vulnerability’s, hurt and pain — that is, healing involves wounding” (1997, p.24). As such, according to Hall, being a healer can be stressful. Furthermore, Hall declared that acknowledging our own
woundedness as nurses provides opportunities not only for personal healing but can improve both collegial and nurse-patient therapeutic relationships.

Given the unique workplace experiences associated with the provision of palliative care, stress-related problems have the capacity to impact upon the nurse’s emotional health. However, to date, research is limited and therefore the need to emphasise wellbeing in nursing is critical, especially in such an emotionally demanding nursing discipline. Moreover, my Honours research (Rose, 2002) not only supported the findings of other scholars but importantly revealed that ‘the link between emotional wellbeing and professional practice was in fact multifactorial and multileveled. Given the current nursing crisis in Australia (Preston, 2002), and consequently greater demands being placed on staff within the clinical arena, additional investigation is required if the nursing profession is to retain its most valuable asset – the nurses.

With the research proposal submitted, it was time to expand my search for additional relevant literature. In the meantime, discussions with my Supervisor had determined that the thesis style would include publications. As we had agreed to co-author, we decided that the first manuscript would be based on the literature review. I will now introduce to you the publication entitled: ‘Nurses and palliation in the community: the current discourse’. The publication details are outlined prior to the paper.

Section two

Increasing the focus: A published literature review

This section will introduce the publication that was developed from review of the relevant discourse up to 2005. Details of the publication are outlined below.

Publication details


Word count: 3570 (excluding abstract and references)
Journal article removed due to copyright restrictions. (pp. 25-31)

International Journal of Palliative Nursing

http://www.ijpn.co.uk/

Full text available online via CINAHL Plus with Full Text (Subscription database)
Conclusion

With the publication now read, the following section will address the literature that was not included in the article. This review will consider scholarship related to emotional work and emotional intelligence prior to moving to Section Four that will consider the latest trends related to the relevant literature.

Section three

Contemporary literature not previously addressed comprehensively

This section builds on other relevant issues that, due to word limitations, were either not adequately addressed or were excluded from the Rose and Glass (2006b) publication in Section Two. The specific areas that will be explored in this section relate to emotional work and emotional intelligence. I have included these discussions as I argue two main points. Firstly I claim that palliative care nursing is intrinsically emotional work given that clients, and their significant others, are living with the process of dying (Burt et al., 2008; Skillbeck & Payne, 2003; Wallerstedt & Andershed, 2007). I additionally claim that providers of palliative care, such as community nurses, are required to actively implement strategies that aim to effectively direct and manage their emotions during care, hence my claim that palliative care involves emotional work.

Within the discussion of emotional work arises the concept of emotional intelligence - that being associated with the regulation of emotions. In keeping with feminist methodology to value the voices of the women participants, my claim that palliative care involves emotional work has yet to be substantiated by the community nurses participating in this study. As there is limited literature that directly addresses emotional work and palliative care, the following review will incorporate various perspectives primarily related to nursing and will include supportive literature from education and psychology. The literature that is most relevant to the following discussions will be outlined in the tables 2.1 to 2.4 below.
Palliative care as emotional work

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Topic</th>
<th>Qual/quant</th>
<th>Methodology</th>
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<td>Scholarly</td>
<td>Concept review and model development</td>
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<td>Scholarly</td>
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<tr>
<td>Skillbeck &amp; Payne</td>
<td>2003</td>
<td>Emotional work - the role of CHNSs</td>
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<td>N/A</td>
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</tr>
<tr>
<td>de Castro</td>
<td>2004</td>
<td>Emotional vs physical labour</td>
<td>N/A</td>
<td>Scholarly</td>
<td>N/A</td>
</tr>
<tr>
<td>McQueen</td>
<td>2004</td>
<td>Emotional intelligence</td>
<td>N/A</td>
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</tr>
<tr>
<td>Scott-Ladd &amp; Chan</td>
<td>2004</td>
<td>Emotional intelligence in decision making</td>
<td>N/A</td>
<td>Scholarly</td>
<td>Concept review and model synthesis</td>
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<tr>
<td>Mann &amp; Cowburn</td>
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<td>Quant</td>
<td>Statistical analysis</td>
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<tr>
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<tr>
<td>Maunder</td>
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<tr>
<td>Giardini &amp; Frese</td>
<td>2006</td>
<td>Emotional work – reducing negative effects</td>
<td>Quant</td>
<td>Statistical</td>
<td>Questionnaires</td>
</tr>
<tr>
<td>McClure &amp; Murphy</td>
<td>2007</td>
<td>Emotional labour</td>
<td>N/A</td>
<td>Scholarly</td>
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</tr>
</tbody>
</table>

Table 2.1 Literature relevant to the review of emotional labour, emotional work, emotional intelligence

People traversing the journey of life-limiting disease undoubtedly experience intense and complex emotions. Consequently the provision of palliative care requires nurses to engage within the client’s emotional life world. Vachon (2003) reminded practitioners that caring for clients and families, during the palliative stage of their disease, can be both stressful and rewarding and warned that “constant exposure to suffering and loss does take its toll if the caregiver is unaware of the need for caring for self as one cares for others” (p.41). Therefore it can be argued that nursing people who are living with dying is intrinsically emotional work (Burt et al., 2008; Skillbeck & Payne, 2003; Wallerstedt & Andershed, 2007). In addition to the claim that palliative care is intrinsically emotional work, is the claim that provision of palliative care involves emotional work.
Emotional work in palliative care

The emotional nature of palliative care practice requires nurses to regulate their own emotions in order to remain diligent in their practice with clients and their families and significant others. Such interactions are accepted as part of the caring process and congruent with holistic nursing care, yet they place additional demands on the emotions of nurses. As such, the discussions of emotional work and emotional labour are of significance as care outcomes impact on nurses’ and clients alike. To address these aspects of practice, a search of the nursing and psychology literature revealed emotional labour and emotional work as key concepts.

Emotional labour/emotional work

The concepts of emotional labour and emotional work have been central to numerous discussions in nursing over recent years (Bolton, 2000; Dingwall & Allen, 2001; Henderson, 2001; Mann & Cowburn, 2005; McClure & Murphy, 2007; McQueen, 2004; Maunder, 2006; Skillbeck & Payne, 2003; Staden, 1998; Strazdins, 2002; Weir & Waddington, 2008) even to the point of being included as an issue of priority in the ‘National surveillance of psychosocial risk factors in the workplace: An international overview’ (Dollard, Skinner, Tuckey & Bailey, 2007).

A conceptual framework stemmed from the seminal work of Hochschild (1983). The study with flight attendants revealed that emotional labour was likened to a performance, involving surface or deep acting, where the regulation and management of feelings were induced or suppressed “to sustain the outward countenance that produces the proper state of mind in others” (p.7). Emotional labour was regarded as having an economic exchange-value whereas emotional work holds an unwaged use-value. However McClure and Murphy (2007, p.112) have cautioned the dominance of emotional labour, believing “it is unable to fully account for the complexity of professional nurses’ emotional work response behaviours”.

The therapeutic use of self in caring work was explored by Henderson (2001) who examined the notion that nurses’ tendency to engage or detach with clients in their care had inherent gains and losses, therefore this is reflective of the nurses’ approach to the emotional labour of nursing. Henderson’s qualitative study involved forty-nine participants,
and the data collection methods were focus groups and individual interviews. The participants described how they consciously monitored and moderated their emotional responses during care, believing that their emotional engagement was linked to positive client benefits. Furthermore, nurses who reflected on their performance of emotional labour in the care of clients, often recognised the outcomes that such work created. The emotional work could therefore be regarded as a quality and “a necessary attribute of caring in an excellent nurse” (Henderson, 2001, p.136).

Emotional work has the potential to “result in some degree of stress” and if compounded by other organisational and/or work related stress, has the potential to impair nurses’ emotional wellbeing (Skillbeck & Payne 2003, p.527). Mann & Cowburn (2005) also identified the relationship between emotional labour and high levels of stress in nurses. The study with mental health nurses in the United Kingdom (UK) found that “surface acting was a more important predictor of emotional labour than deep acting” (p.154). They recommended additional education be provided to nurses to better manage their involvement in emotional work and agreed with other scholars that nurses’ wellbeing, being central to care, required education to reflect the additional significance of the emotional work in regard to stress outcomes, so that stress management can be modified to reflect an increased importance.

Lawton & Carroll (2005, p.136) highlighted the range of emotions and reactions that terminally ill clients can exhibit when communicating in therapeutic relationships with nurses, for example, “sadness, helplessness, hopelessness, anxiety, fear and even distress”. Establishing caring and supportive relationships with clients and their families requires the therapeutic use of self, similar to the suggestion by Henderson (2001) and in addition, incorporates the nurses’ capacity to manage the emotional work associated with emotions (Dingwall & Allen, 2001). Dingwall and Allen (2001, p.65) used the term “holistic emotional work” integrating the aspects of caring for and caring about clients. Maunder (2006) drew attention to the emotional work associated with the holistic care of children and young people who require palliative care, asserting that “this domain can be one of the most emotionally challenging areas of practice” (p.27). Managing the emotional stress and distress of clients can create challenges for nurses. Regulating and managing the emotions associated with palliative care practice has been considered complex as one negotiates the emotional work within such an emotionally demanding practice.
Palliative care nurses also applied metaphors such as, being drained and burdened, to express the emotional load associated with palliative care (Froggatt, 1998). Within the discourse scholars began to recognise the concept of emotional intelligence and its relationship to emotional work, see for example, the literature in business (Scott-Ladd & Chan, 2004), psychology, (Giardini & Frese, 2006; Goleman, 1995; Grandey, 2000;) and nursing (McQueen, 2004; Reeves, 2005). To define the concepts of emotional work and emotional intelligence I refer to the work of Giardini and Frese who, whilst they substituted the term emotional intelligence for emotional competence, explained that: 

\[
\text{[e]motional work is the regulatory effort to express organizationally desired emotions, whereas emotional competence encompasses skills that focus on how people deal with and regulate their own affect and that of others (2006, p.63).}
\]

Grandey’s (2000) scholarly work on regulating emotions in the workplace contributed to my understanding of emotional intelligence. Grandey (2000) reviewed and compared pre-existing perspectives related to emotional labour and presented a model that incorporated situation cues, emotional regulation process and long-term consequences, providing a framework worthy of consideration. The model proposed by Scott-Ladd and Chan, (2004) synthesised how emotional intelligence, organisational learning and participation in the decision-making process can enhance employee capacity for change and improved performance.

McQueen (2004) and Reeves, (2005) both highlighted the importance of emotional intelligence to the emotional work involved in nursing practice. As stated earlier and reiterated by both scholars, nursing is a complex profession and engaging in interpersonal relationships with clients, family and professional colleagues are unavoidable. McQueen (2004, p.106) strongly asserted that, “emotional work calls upon some of the skills that fall within emotional intelligence... [and] management of emotions is required in successful interactions”. Emotional intelligence involves three key factors those being: awareness of self; awareness of others; and empathy (Reeves, 2005).

It would be difficult to dispute the assertion that palliative care nursing is “demanding and skilled work” (Skillbeck & Payne, 2003, p.525) therefore the emotional impact on nurses’ wellbeing should not be overlooked. Scholars have outlined the value of emotional intelligence in regulating the emotions associated with nursing work. As de Casto (2004,
p.3) asserted, “the impact of emotional labour on nurses’ well-being is not fully realized or appreciated” yet one fact is clear, that:

[n]ursing is a complex profession that requires professional nurses to interact holistically with a variety of individuals in a high-stress environment.

This section provides insights into the contemporary literature related to emotional labour, emotional work and emotional intelligence. The review explored the three concepts and their relevance to contemporary nursing practice. It was revealed that within palliative care practice, nurses therapeutically engage in a caring process that involves emotional work. Scholars highlighted the significance of implementing emotionally intelligent strategies to counteract the impact that emotional work could have on nurses’ wellbeing. With this section complete, I will now discuss the current trends that have emerged between 2006-2008.

Section four: Current trends 2006-2008

Introduction

The aim of this section is to ensure that the current trends in literature published between 2006 and 2008 are reviewed. New searches were undertaken, primarily electronic, using a variety of key words in various nursing databases. One psychology database was searched which returned no relevant results. The nursing databases accessed included GALE CENGAGE Learning; Wiley; OBSCO Host and ProQuest. Additional independent searches of nursing journals were also undertaken. Whilst the following review incorporates international scholarship, I attempted in the first instance to focus the initial searches on Australian literature to see what recent research had been undertaken. The electronic results using relevant key words are detailed in the table 2.2 below.
Table 2.2 Databases and results

As could be seen in table 2.2 the terms community health nurses and district nurses were used as both titles represent the generalist role in Australia. The searches elicited a lesser than expected response. The central themes related to the literature are outlined in table 2.3 below.

<table>
<thead>
<tr>
<th>Client care</th>
<th>Health promotion</th>
<th>Nursing history</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing stress</td>
<td>Client support</td>
<td>Psychosocial care</td>
</tr>
<tr>
<td>Clinical issues</td>
<td>Competency standards</td>
<td>Nursing research</td>
</tr>
<tr>
<td>Client referrals</td>
<td>Care continuity</td>
<td>Home nursing culture</td>
</tr>
<tr>
<td>Information resources</td>
<td>Preventative health</td>
<td>Residential aged care</td>
</tr>
<tr>
<td>Education</td>
<td>General practice nursing</td>
<td>Specialist practitioners</td>
</tr>
<tr>
<td>General practitioners</td>
<td>Interdisciplinary communication</td>
<td>Nurses’ role in primary care</td>
</tr>
</tbody>
</table>

Table 2.3 Central themes related to the literature

Extended searches were ultimately undertaken in search of additional relevant literature. The searches reaffirmed that there is limited literature related to community nursing palliative care practice. As a consequence, particularly in Australia, the knowledge of the relationship between emotional wellbeing of the community nurses and their professional practice is sparse. This notwithstanding what follows is a review of the available literature that informs this study. There are two sub-sections and these are: Sub-section one -
Community health nursing; and Sub-section two - Community health nursing and palliative care. I begin with a discussion of the recent discourse related to Sub-section one - Community health nursing. The relevant literature is outlined in Table 2.4 below.

**Sub-section one - Community health nursing**

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Topic</th>
<th>Qual/quant</th>
<th>Methodology</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkinson</td>
<td>2006</td>
<td>Meeting role challenges</td>
<td>N/A</td>
<td>Scholarly</td>
<td>N/A</td>
</tr>
<tr>
<td>Hall &amp; McWilliam</td>
<td>2006</td>
<td>Nursing culture</td>
<td>Qual</td>
<td>Ethnography</td>
<td>Triangular</td>
</tr>
<tr>
<td>Coleman &amp; Lynch</td>
<td>2006</td>
<td>Clinical supervision</td>
<td>N/A</td>
<td>Scholarly</td>
<td>N/A</td>
</tr>
<tr>
<td>Abbott et al</td>
<td>2006</td>
<td>Clinical supervision</td>
<td>Qual</td>
<td>Not stated</td>
<td>Education and groups</td>
</tr>
<tr>
<td>Brookes et al</td>
<td>2007</td>
<td>Role theory</td>
<td>N/A</td>
<td>Scholarly</td>
<td>Literature review</td>
</tr>
<tr>
<td>Davy</td>
<td>2007</td>
<td>Role flexibility</td>
<td>N/A</td>
<td>Scholarly</td>
<td>N/A</td>
</tr>
<tr>
<td>Jenkins</td>
<td>2007</td>
<td>Clinical supervision</td>
<td>Qual</td>
<td>Co-operative inquiry</td>
<td>Storytelling &amp; reflective appraisal</td>
</tr>
<tr>
<td>Fletcher</td>
<td>2008</td>
<td>Clinical supervision</td>
<td>Qual</td>
<td>Descriptive</td>
<td>Education sessions/ Self-evaluation</td>
</tr>
</tbody>
</table>

**Table 2.4   Literature relevant to the review of community health nursing**

I was mindful of the changes to community health nursing practice as a result of the shift from “primary to short-term clinical care” that Kemp, Harris and Camino (2005, p.307) had identified, and the ongoing challenges that the nursing profession encounters as a result of ongoing government changes. On both a local and global level, nursing shortages and the demands on health care services continue to be a major cause of concern. The impact of these pressures can result in role conflict, stress and burden for nurses (Brookes, Davidson, Daly & Halcomb, 2007). Whilst community nursing continues to modify in accordance with organisational change, it is important that the primary health care focus is not lost to acute care services. Yet with shorter hospital stays secondary to early discharge, community health nurses were having to respond to clients’ post-discharge acute care needs in addition to their primary health care focus (Brookes et al., 2007). The authors therefore warn that the community nurse role could become more vulnerable.
In addition, other scholars have acknowledged the long held belief of community nurses that their roles are diverse, complex and multifaceted (Davy, 2007; Hall & McWilliam, 2006; Parkinson, 2006; Rose & Glass, 2006a, 2008a). Increased complexity is evident due to health services changes that have resulted in some community health services developing strict criteria to limit the number of referrals (Parkinson, 2006). That in turn has raised concern over the nurses’ capacity to adequately carry out complex and ongoing holistic nursing assessments, consequently reinforcing a previously held view that the community nurses are inflexible (Parkinson, 2006). However the suggestion of inflexibility in regard to holistic nursing assessment can be strongly debated by other nursing scholars.

In the United Kingdom, Davy (2007, p.20) strongly argued that the community nursing teams are a “flexible and hard-working workforce”, asserting that ‘anyone who knows their work could not say otherwise’. In Australia the flexibility associated with the clinical practice and hard working nature of community nurses was also clearly indisputable (Rose & Glass, 2006b). In the ethnographic study by Hall and McWilliam (2006) involving ten Victorian community nurses and voluntary clients, the researchers captured the experiences of ‘in-home’ nursing first hand, revealing the complex nature of empowerment and disempowerment in nurse/client relationships. The study sought to identify the actions, practices, values and beliefs that collectively comprise the culture of in-home nursing. The findings clearly highlighted the ongoing and complex process of assessment that takes place during nurse/client interactions.

One of the key findings of the study was the insight provided into the nursing culture. The researchers found that:

The culture of in-home nursing to be one in which nurses act as professional experts and persons receiving nursing care as compliant “patients”. Despite nursing’s theoretical espousal of empowering, caring relationships, the predominant expert model of service delivery prevailed (Hall & McWilliam, 2006, p.84).

The problem however, was the empowerment/disempowerment imbalance observed within the nurse/patient interactions. The findings, whilst extremely valuable, contrasted those of other scholars who emphasised that empowerment of clients maximised their capacity to reach their full potential, therefore client empowerment was a prime focus of community nursing practice (Rose & Glass, 2006b). The dichotomy could relate to the variance in
research aims and methods applied to the research. A critical analysis of the findings of the study by Hall and McWilliam (2006) provided valuable insights into the juxtaposed positions that those nurses faced between providing collaborative and holistic care, yet simultaneously identified nurses’ as being challenged by lack of resources to ensure optimal capacity to care.

Whilst Hall and McWilliam (2006) strongly urged that community nurses consider the nature of their care and the way in which they provide care to clients living at home, the limitations of the study prevented exploration of support for nurses to address the outcomes reached. One of the solutions could involve implementing support for community nurses by way of clinical supervision. There is little doubt that programs vary according to their aim and that the cost of supporting a program requires “sustained investment of service time and money” (Coleman & Lynch 2006, p.37). The authors also caution that implementation of such a program can be accompanied by problems however, the question of value should then be “what is a nurse worth?”.

Clinical supervision is provided to community health nurses in the UK (Davy, 2007; Jenkins, 2007) and in specific health trusts is regarded as “mandatory” for all nursing staff (Abbott, Dawson, Hutt, Johnson & Sealy 2006, p.346). Yet in Australia, clinical supervision remains a novel concept according to Fletcher (2008) and community nurses are generally denied those opportunities unless they work in specialty areas for example, mental health or drug and alcohol services. With changes to health services in Australia, nurses are in search of support on many levels and as Fletcher (2008, p.196) argued, that the “old skills, strategies and support frameworks were no longer sufficient” to support the emotional intensity experienced by the community nurses in that study.

Fletcher’s (2008) evaluation study of a clinical supervision program was undertaken in rural Victoria, Australia, and involved seven community nurses. The first level of analysis reported on the usefulness of the social work model to be used. The model was specifically chosen as community nurses were increasingly providing counselling support to clients as a result of new nursing programs being introduced. Whilst limited details were outlined regarding the number of supervision sessions, the nurses’ perceived ability to counsel and their confidence in counselling increased as a result.
Both Abbott et al., (2006) and Jenkins (2007) reported positive outcomes to their supervision programs whilst simultaneously demonstrating, as did Fletcher (2008), that supervision models integrated to support community nurses must be designed in accordance with the predetermined needs. That notwithstanding, the insights are worthy of reflection as researchers believe that not only will “patients benefit from the restorative effects of clinical supervision” (Abbott et al., p.348) but moreover, the journey became one of praxis as nurses “learned to co-create understanding, through mutual support and challenge” (Jenkins, 2007, p.69).

It is evident from the literature that community health nurses are encountering the pressures associated with fiscal restraints, organisational changes and an increase in client acuity over primary health care. As the complexity of practice increases, so do the challenges and demands. These have implications on community health nurses and subsequently, on the recipients of care. Clinical supervision was revealed as a support strategy for that could enhance outcomes for community health nurses and their clients. Sub-section two will expand the review by considering community health nursing and palliative care practice. Table 2.5 highlights the relevant literature that will be discussed.

**Sub-section two - Community health nursing and palliative care**

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Topic</th>
<th>Qual/quant</th>
<th>Methodology</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trueman &amp; Parker</td>
<td>2006</td>
<td>Palliative care and life review</td>
<td>Qual</td>
<td>Descriptive</td>
<td>Focus groups</td>
</tr>
<tr>
<td>Hughes et al</td>
<td>2006</td>
<td>Education program for CHNs</td>
<td>Mixed</td>
<td>Longitudinal</td>
<td>Questionnaires</td>
</tr>
<tr>
<td>Oudshoorn et al</td>
<td>2007</td>
<td>Client/nurse relationships</td>
<td>N/A</td>
<td>Critical</td>
<td>Secondary data analysis</td>
</tr>
<tr>
<td>O’Hara et al</td>
<td>2007</td>
<td>Education needs of CHNs</td>
<td>Mixed</td>
<td>Not stated</td>
<td>Questionnaires &amp; groups</td>
</tr>
<tr>
<td>McKenzie et al</td>
<td>2007</td>
<td>Health and social care</td>
<td>Qual</td>
<td>Descriptive</td>
<td>Observations &amp; interviews</td>
</tr>
<tr>
<td>Wallerstedt &amp; Andershed</td>
<td>2007</td>
<td>Palliative care outside special palliative care settings</td>
<td>Qual</td>
<td>Phenomenology</td>
<td>Interviews</td>
</tr>
<tr>
<td>Shipman et al</td>
<td>2008</td>
<td>Principles of practice</td>
<td>Mixed</td>
<td>Empirical</td>
<td>Interviews &amp; questionnaires</td>
</tr>
<tr>
<td>Burt et al</td>
<td>2008</td>
<td>Caseloads</td>
<td>Qual</td>
<td>Framework approach</td>
<td>Focus groups</td>
</tr>
</tbody>
</table>

Table 2.5 Literature relevant to the review of community health nursing and palliative care
It was argued that community nursing has become increasingly complex (Davy, 2007; McKenzie et al., 2007; Rose & Glass, 2006b;) with nurses’ multiplicitous roles involving ‘hands on’ care, education, emotional support and comprehensive client assessments. The complexity of the role has reached a point where the nurses “could almost be categorised as social workers with the added benefit of expert nursing skills over and above that” (Davy 2007, p.19). Whilst caring for clients in the community is acknowledged as increasingly complex, scholars have also identified strong relationships between nursing work, work environments and patient and nurse outcomes (Flynn, 2007; Hall, Doran & Pink, 2008; Latham, Hogan & Ringl, 2008; McKenzie et al., 2007). This issue is of prime importance and supports the need for additional research on the wellbeing of nurses.

In the recent discourse, community nurses have strongly articulated their belief that they play a central role in the provision of palliative care to clients living at home (Burt et al., 2008), yet tension exists as nurses combat disempowerment through organisational issues that can significantly impact on their emotional wellbeing (Burt et al., 2008; Wallerstedt & Andershed, 2007). In addition, nurse/client relationships act as a measure for job satisfaction, dissatisfaction, empowerment and disempowerment (McKenzie et al., 2007; Oudshoorn, Ward-Griffith & McWilliam, 2007;) and moreover, the education needs of community nurses (Hughes et al., 2006; O’Hara, Byron & Moriarty, 2007; Shipman et al., 2008 Trueman & Parker, 2006) should be regarded as significant to both nurse and client outcomes.

When exploring nurses’ experiences of palliative care practice, two projects were of particular interest. The first, a study by Wallerstedt and Andershed (2007), focused on the care of dying patients outside of a special palliative care designated setting. The Swedish study, both qualitative and descriptive, involved nine nurses from community, district and hospital settings. Interviews generated data that would provide insights into the life-worlds of the nurses, whilst engendering reflection to uncover their experiences of caring for dying clients. The second study by Burt et al. (2008) was a purposive sample involving fifty-one community nurses working in four primary health care trusts in the UK. Data were collected through nine focus groups with an aim to explore the nurses’ perception of their palliative care role and their perceptions of providing end of life care within the context of their generalist workload.
Whilst both studies differed in aim, similarities were uncovered in the findings that were of particular relevance to my study in regard to: *the community nursing palliative care role; demands and challenges; the emotional impact of palliative care; job satisfaction/dissatisfaction; and emotional support and self-care.* These elements will be discussed whilst integrating additional literature that will enhance the understanding of nurse/client relationships. In addition, a discussion on *educational issues* will provide insight into the programs designed to enhance community nurses’ provision of palliative care.

**The community nursing palliative care role**

Many community nurses believed that caring for dying clients was a demanding role that “demanded great dedication that could comprise both positive and negative elements” (Wallerstedt & Andershed, 2007, p.34). However the significant point was that nursing care engendered quality for clients and family and, of most importance, was designed to accommodate the uniqueness of those in their care. Nurses in both studies reported providing ‘hands on’ care to clients managed in conjunction with their generalist client workload (Burt et al., 2008; Wallerstedt & Andershed, 2007). Client care incorporated both physical and emotional elements, however tension existed when managing the additional responsibilities related to ongoing assessments, organisation and coordination as these created additional challenges the wellbeing of nurses.

**Demands and challenges**

Care of terminally ill clients was time consuming and unpredictable (Burt et al., 2008, p.1474) and the ability to work collaboratively was considered a prerequisite to optimising the opportunity for what was regarded as “a good death” (Wallerstedt & Andershed, 2007, p. 34). Time pressures and lack of human resources resulted in nurses feeling frustrated, reporting inadequate meal breaks placing extra demands on nurses. Staff shortages meant “longer heavier caseloads” (Burt et al., 2008, p.1475) with acknowledgment that busy workloads led to overflowing in-trays and paperwork backlogs. Nurses sought collaborative working relationships with clients and colleagues to implement quality care however, the workplace pressures were clearly a source of disempowerment for the nurses. Furthermore, the emotional demands associated with caring for dying clients resulted in additional stress.
The emotional impact of palliative care

Nurses in both studies expressed the emotional impact of caring for dying clients however not all of the community nurses believed that their role in palliative care was acknowledged by senior staff or management. One nurse remarked “but nobody higher up acknowledges now the percentage of our workload this takes. And the emotional impact” (Burt et al., 2008, p.1474). Intensive client contact and many deaths in a short time, were additional causes of stress that resulted in fatigue for some nurses (Wallerstedt & Andershed, 2007) with the emotional impact evident as one nurse told of “crying my eyes out, because I’d just had a really awful visit” (Burt et al., 2008, p.1475). The emotional impact related to the stress was reflected in the nurses’ perception of job satisfaction/dissatisfaction.

Job satisfaction/dissatisfaction

Palliative care provision was a source of professional satisfaction for the nurses in both studies. Satisfaction was achieved when being given the opportunity to care for palliative clients’, however making a difference to the clients’ quality of life was an optimal reward. The findings also reflected personal and professional growth for nurses however the juxtaposed positions that were experienced, as end of life care, whilst stimulating, and confirming, could also be burdensome and demanding (Wallerstedt & Andershed, 2007).

Whilst the nurses’ relationships with clients and families were reported as stimulating, satisfying, and generating feelings of happiness and generosity for nurses (Wallerstedt & Andershed, 2007), other scholars have utilised alternative lenses to examine the nurse/client relationships. Therefore notwithstanding the importance of the previous findings, other scholars have reported the hierarchy of power that can dominate relationships in home-based palliative care (Oudshoorn, Ward-Griffin & McWilliam, 2007).

Applying a critical lens to analyse the UK qualitative study, interview transcripts from seventeen nurses and sixteen clients were reviewed (Oudshoorn et al., 2007). The researchers’ illuminated three levels of power that challenged the relationships, those being, macro (Powerlessness of nurses), meso (Exercise of power between nurses and clients) and micro (powerlessness of clients). Whilst the researchers highlighted that the hierarchy of power “is not necessarily wielded negatively” (p.1442) the scholars argued that
“if nurses’ feel powerless with their workplaces, it is unlikely that they will enact liberation in their relationships with clients” (Oudshoorn et al., 2007, p.1441).

A dialectical tension clearly existed for nurses in this study as they encountered organisational oppression, whilst striving to deliver care that was overshadowed by oppression yet intended to be empowering. Nurse domination led to states of disempowerment for clients, resulting in either passive acceptance or alternatively, resistant behaviours that reinforced personal power. The findings created new insights into the nurse/client relationship and therefore are valuable to the nursing profession. Whilst presenting new challenges for nurses to apply reflective practices, acknowledgement, identification and action could be reflected positively in both nurse and client outcomes. According to McKenzie et al. (2007) regularity in home visits to clients living with cancer, engendered a strong sense of security that held as significant to both the client and carer’s physical and psychological wellbeing. Whilst the nurse/client relationship had a significant impact on all individuals, as outlined above, it is important to consider the sources of dissatisfaction that could impact on the nurses wellbeing and potentially client care.

In the study by Burt et al. (2008) the community nurses were at times left feeling like the ‘gofer’, picking up tasks that other service providers didn’t want. In addition, the lack of time to provide optimal client care reported in two studies (Burt et al., 2008; Wallerstedt & Andershed, 2007) contributed significantly to the nurses’ experiences of job dissatisfaction. This could be likened to the feelings of powerlessness that the nurses in Oudshoorn’s et al., (2007) study raised as a consequence of the fiscal pressures that hindered their nursing practice. Also of particular significance were the results of Wallerstedt and Andershed (2007, p.37) study when they reported, “despite the need, the nurses experienced insufficient support from managers and little understanding and little commitment regarding their physical and mental health”. These experiences can result in further disempowerment for nurses, thus contributing to their marginalised position as nurses. With such an impact it is necessary that nurses take steps to care for themselves and seek support to address this position of disempowerment.

**Emotional support and self-care**

Nurses in both studies reported feeling emotionally drained as a result of their palliative care practice and nurses generally utilised informal debriefing as a self-care strategy.
Given the value placed by community nurses participants on the nurse/client relationships, experiencing grief and loss could be a reasonable possibility. Burt et al. (2008) described how the nurses demonstrated a degree of ambivalence related to caring for dying clients and focused on the need to develop formal channels of support, such as clinical supervision, in order to avoid burnout. However in contrast, some nurses in Wallerstedt and Andershed (2007) study did have access to clinical supervision yet were unable to attend due to lack of time. Support strategies such as clinical supervision require important consideration and, most importantly, “should be available to all members of [community nursing] teams” (Burt et al., 2008, p.1477).

**Educational issues**

Palliative care provision is accepted as a core responsibility of the community nursing role (Davy, 2007) with generalist nursing teams identified as the ‘mainstay of “hands-on” care at home’ (Shipman et al., 2008). Research has been undertaken in the UK by various scholars seeking to either assess (O'Hara et al., 2007; Trueman & Parker, 2006), or evaluate (Hughes et al., 2006; Shipman et al, 2008), the education needs of community nurses involved in palliative care provision.

One study explored ‘life review as a therapeutic intervention for younger people requiring palliative care’ (Trueman & Parker, 2006, p. 197). The three additional studies used questionnaires to ascertain the education needs of community nurses. Education programs were then developed and implemented. The studies, all undertaken in the UK, developed programs that were context dependent and flexible, providing nurses with various opportunities to expand their professional development. The nurses required education on a variety of clinical issues, such as pain and symptom control plus psychosocial skills, such as communication and counselling. Programs were run at various times and locations in efforts to accommodate all participants.

The final evaluations provided evidence of the programs’ success. The education facilitated by the MacMillian nurses identified that the profile of palliative care was lifted and the generalist nurse participants believed that their education and support needs had been met. Of critical importance to the wellbeing of participants was that the process created a feeling for the nurses of being heard. The outcome was increased confidence in the
nurses’ ability to communicate with clients and with less fear when addressing end of life issues (O’Hara et al., 2007).

In the program outlined by Hughes et al. (2006), the community nurses placed priority on communication, care addressing depression/withdrawn clients and bereavement. The facilitators of this program were multidisciplinary team members inclusive of Macmillan nurses, medical practitioners, specialists, a consultant psychiatrist and a clinical psychologist. The nurses felt valued, as they were involved in the determining the educational content. Confidence in palliative care practice increased for the generalist nurses, showing sustainability over the following year.

Addressing the education and ongoing professional development needs of community nurses is critical, given the pivotal role the nurses have in palliative care provision. As the preceding discussions have highlighted, the emotional demands of palliative care can result in nurses’ emotional wounding. Steps should be taken to make visible the needs of nurses in order to provide opportunities that will enhance skills, knowledge and capacity to care for themselves and their clients.

**Conclusion**

This Chapter has provided a review of the contemporary discourse relevant to this study. In Section One I presented the foundational work undertaken in the early development of this research. Section Two introduced the co-authored publication entitled ‘Nurses and palliation in the community: The current discourse’ that reviewed relevant literature up to 2005. In Section Three I reviewed literature that had been previously omitted and/or limited in the prior reviews. Finally in Section Four I discussed the relevant discourse that explored the current trends, associated with community nursing and palliative care practice, between the years 2006 – 2008.

This Chapter provided insights into the contemporary discourse associated with community health nursing and palliative care practice. Many scholars raised awareness of the complex and challenging issues community health nurses encounter in their practice. There is an additional burden being placed on community health nurses as a result of changes to health delivery, particularly due to increased client acuity, reducing opportunities for holistic
primary health care. Compounding the issues are fiscal restraints, increased workloads and less resources.

The emotional demands associated with palliative care practice and, in particular the emotional impact of caring for dying clients was revealed. Researchers reported on clinical supervision and education as support strategies to enhance nurses' wellbeing, yet barriers to access were increased by busy workloads. The discourse identified that the demands associated with palliative care were juxtaposed by job satisfaction. Whilst nurses valued their interpersonal relationships, their workplace environments remained disempowering and oppressive and this resulted in stress. Of most significance to my study was the relationship between the palliative care practice and nurses' wellbeing. The complexity of generalist palliative care was acknowledged and the impact to nurses' emotional wellbeing, as a consequence of workplace issues, was made evident. The literature highlighted the demands and challenges community health nurses encountered and made evident the emotional impact. Staff shortages and heavy workloads could affect job satisfaction thus, emotional support and self-care were necessary. Whilst the literature identified a multiplicity of issues that provided valuable insight into community health nursing and palliative care, the Australian contributions were limited. Therefore it is aimed that this study will contribute to the existing literature, particularly in relation to nurses' self-care and support processes.
Chapter Three

Methodology:
An emancipatory inquiry
Chapter overview

In the previous chapter I drew attention to the current discourse on issues related to community nursing, palliative care and community nursing palliative care. In this chapter, I will explore the chosen methodological approaches that underpin this study followed by a discussion of the two research methods, those being, semi-structured interviews and reflective journaling. It will be strongly argued that the emancipatory framework applied to this study is appropriate to meet the research aims and objectives whilst, simultaneously offering opportunities for the women and nurse participants to ‘speak from their heart’.

Inherent in this methodology is a critical social science and feminist vision as both philosophies are underpinned by emancipatory objectives. Whilst these philosophies are socio-political methodologies that seek to explain the social world, create meaning and bring about social change, they were not adequate as individual philosophies to address for this investigation. Critical social science was chosen to examine nurses in their health care positions and feminist theory was chosen to examine women’s socio-political positions. Furthermore as the emancipatory agenda often includes both critical and feminist paradigms, I have discussed critical social science and feminist theory separately in the ensuing chapter, to ensure that I gained a satisfactory understanding of each.

In addition to the above, ethical issues significant to qualitative approaches such as ensuring validity and credibility and the importance of intersubjectivity and reflexivity, will also be considered in this chapter. Furthermore, to enhance the credibility and ensure transparency in the research process, I have included my epistemological and ontological position and my reasons for taking such a political stance. The final section of this chapter will be the inclusion of an article entitled: The importance of emancipatory research to contemporary nursing practice. This paper was developed from the contents of this chapter and was published in the internationally peer reviewed journal Contemporary Nurse in 2008. Full details will be provided when introducing the article.
To begin the discussions in this chapter, I pose an analogy that is aimed to signify an emancipatory process that had recently impacted on my life - that specifically, living in a rural community facing change.

**In the face of change**

In recent times the local hamlet had cheerfully celebrated the closing of a bridge that had, for many years, been the link between communities north and south of the Brunswick River in Northern NSW, Australia. Many people publicly reminisced its history, reflecting on their many crossings on horse drawn carts, pony rides to school and the fish that did or did not get away. In effect, the bridge no longer met the current demand of highway traffic and it was time for change.

Consultations resulted, amidst community angst regarding the proposed changes, with locals seeking answers to questions concerned with ‘why a new bridge’; ‘whose purpose is the change serving’; and, ‘at what environmental cost’. With due process followed, plans were drawn and foundations laid. Commuters travelling through the Northern Rivers of New South Wales now experience a bridge that will see them well into the next century. Whilst this change can be seen inevitably as positive progress, for the local community who felt their voices were not heard, the struggle continues.

Such a resistance to change is not an uncommon phenomenon, and to make visible the concerns created new opportunities to gain a deeper sense of understanding. With new insights gained, the people had little choice other than to support the two-bridge construction. Perhaps with heavy hearts, for the local residents to deny progress in this case would have been at the expense of the broader community. The change was supported/accepted thus ensuring safer travel and the potential to reduce harm. Without disrupting the status quo and raising the consciousness of the local people, a new emancipatory vision would not have been realised.

In terms of nursing, resisting change and maintaining the status quo could be argued as lack of awareness and, in some aspects, perhaps abusive in that it neglects to adequately address the needs of nurses and patients. Analogous to the bridge, raising the consciousness of nurses and the profession through critical methodological approaches is
part of transformation and change. Furthermore, with a central focus on women, critical theory that is informed by feminist epistemology provides a constructive foundation to emancipate women and nurses who experience marginalisation and oppression.

**The researcher’s position**

It is essential in any research that ethical compliance is adhered to in order to enhance research credibility. Although an extended discussion on ethical considerations relevant to this research will be introduced later in this chapter, it is necessary to ground myself in this research. Therefore my socio-political position is discussed at the forefront of this chapter. My position in this study is situated in the duality of researcher and participant, a position that embraces the principles of reflexivity and transparency, both congruent with critical and feminist qualitative research paradigms (Dowling, 2006).

The research methodology applied to this study culminated from several discussions with my Supervisor. Considerations were given to the aims of the research and the proposed questions and subsequently a critical paradigm underpinned by a feminist framework was deemed methodologically congruent. This approach was also politically aligned with my epistemological and ontological position as a woman and nurse. Moreover this approach supported my belief, along with that of others, that women and nurses experience varying degrees of marginalisation and oppression (Ogle & Glass, 2006; Roberts, 2000).

In addition, having worked in various institutional and community settings as a registered nurse, I continue to be consistently challenged by the unequal power relationships that exist within health care. The patriarchal supremacy remains present, disguised by opposing masks of blatancy or surreptitious coercion. Applying a critical feminist philosophy enables the research to take a political position that is directed toward critically examining the structures and knowledge that seek to maintain the oppressive environments in which nurses work. Highlighting such inequities, disrupting and challenging the status quo such as critical methodologies do, create possibilities for emancipatory outcomes that are central to the research intent (Kincheloe, 2004).

Having outlined my political position in regard to this research I invite you to explore the relevant methodological consideration related to critical and feminist theory.
Methodological considerations: An overview

Having designed the research question, it was then necessary to ensure that the methodology would provide clear opportunities for the participating nurses to examine the social world associated with their clinical practice. Applying a humanistic approach such as that offered by critical social science, would intentionally seek to “simultaneously explain [the community health nurses] social world, criticize it, and empower [the community health nurses] to overthrow it” (Fay, 1987 p.23). Therefore it was anticipated that once enlightened, the community health nurses would experience various states of empowerment that would optimally lead toward emancipatory outcomes.

Additionally, as the research involved working exclusively with women community health nurses, it was essential that the frame of the critical inquiry reflected a theoretical approach that demonstrated a central focus on attempting to understand women. Moreover it was essential that the methodological framing valued and validated women’s multiple ways of knowing and subsequent experiences. Feminism like critical social science is a critical methodology centrally focused on empowerment and emancipation. Feminist theory is critical in that it seeks to attain women’s power and freedom (Taylor, 2007) and through applying feminist principles, research is undertaken ‘by’ women and ‘for’ women (Glass, 2000).

It was therefore necessary to ensure that the chosen research methods to be applied to this study were congruent with the emancipatory intent. Additionally, it was critical to remain mindful of the potential emotions that may be associated with sensitive research such as that of palliative care. It was crucial that participants were provided with opportunities to speak freely, having their voice/s heard whilst simultaneously feeling supported during that experience.

After consideration, the methods applied were semi-structured interviews and reflective journaling. During 2006, following Southern Cross University Human Ethics approval, (Appendix One) interviews were conducted with sixteen women community health nurses located in clinical practice across rural and urban New South Wales, providing a wealth of unique experiences. The findings of the research will be discussed in Chapter Four.
Critical paradigms

As feminism and critical social science are usually viewed under the qualitative critical methodological umbrella (Polit & Beck, 2004; Taylor, 2007), I have considered it most relevant to highlight the key characteristics of both paradigms independently. Included in these discussions are seminal contributions from early scholars interwoven with relevant contemporary literature.

Critical theory to critical social science

It has been acknowledged by contemporary scholars that a precise explanation of critical theory is difficult as “critical theory is never static; it is always evolving, changing in light of new theoretical insights and new problems and social circumstances” (Kincheloe & McLaren, 2008, p.407).

Critical social science emerged from critical theory dating back to the 1920s with critical social science underpinning many of the feminist standpoints. According to Agger (1998, p.180) “critical social science is dialectical, not utopian; it concentrates on analysis and critique, not the drafting of blueprints of how people will live in a distant future”. Whilst doing justice to all of the critical traditions would be impossible Olesen (2008), the concept of critical theory held historical links to the renowned philosophers and social theorists such as Adorno, Horkheimer, Habermas and Marcuse who were amongst the original interdisciplinary scholars from The Institute of Social Research, as it was initially known, and was later to become known as the Frankfurt School, founded in 1923 (Agger, 1998; Campbell and Bunting, 1991).

The critical theorists were disturbed by the Marxist approach of natural scientists who sought knowledge through objective data by applying logical deductions using empirical observations (Hedin, 1987). The scientists argued that “nature must be conceived as a ‘subject’ and not an ‘object’ ” (Agger, 1998, p.87) and believed that by contributing subjective forms of knowledge such as human experiences to the more traditional forms of deterministic objectivism, that the scientific value would be realised (Abbott, Wallace & Tyler, 2005; Campbell & Bunting, 1991). The rise in fascism within the European culture
was instrumental to theorists seeking to understand the political arena and in developing an alternative theory that focused on emancipation in contrast to authoritarianism.

Thus the foundation of critical theory “dictated that knowledge should be used for emancipatory political aims” (Campbell & Bunting, 1991, p.4) and therefore having a primary focus on bringing together the concern of philosophy with holistic analysis with the intent of human emancipation by bringing about social change (Seidman, 2004). However, Scrambler (2001, p.10) prompted caution, suggesting that it would be “inappropriate to attribute exclusive proprietorship to the Frankfurt School philosophers as critical theory was seen to evolve over many years”.

It is from that stance that Fay (1987) lay preference to the term critical social science. This was not only to reposition it from the historical connection with the Frankfurt School, but moreover, to differentiate the confusion in meaning of critical theory that being, a theory of ‘science’ as opposed to critical social science being a theory of ‘society’. Tew (2002) claimed that the meaning and context of critical theory has differed with its use. However, critical theory has retained its core value, that being “to probe beneath the surface in order to find what may lie hidden there” (Tew, 2002, p.17).

The critique of culture exposing the problems faced by societies has evolved, hence the foundation of modern critical theory has been attributed to Karl Marx (Crotty, 1998; Fay, 1987; Harvey, 1990). Modernity witnessed the move toward humanism and the aspiration that an increased theoretical knowledge would ultimately transform human existence. Hence the modern period was aligned with “revealing the true essence of labour, formerly lost beneath a morass of extraneous social relations” (Cannon, 2001, p.1) and in so doing, created the potential for critical theory to challenge the injustices and causes of oppression that deemed to hinder social change.

However, Fay (1987) argued that the most recent contributions of critical theorists such as Horkheimer, Adorno and Marcuse suggested that modernity offered a unique opportunity “to insulate itself from genuine critical theory and its emancipatory intent” (p.6). As a result of that belief, Fay (1987) reinforced his conviction in the viability of critical social science, asserting that it “can provide an important source of social understanding and a much-
needed impetus for the social and political changes which will have to take place if human life is to continue” (p.ix).

Marx’s (1943) definition of critical theory, “the self-clarification of the struggles and wishes of the age” (as cited in Fraser, 1987, p.33) was revered by Fraser for its ‘straightforward political character’. However, the complexity of Marx’s critical theory of capitalist society was considered by Fay (1987) to be strongly open to interpretation. In order to be recognised as a natural science and to prevent his theories from being considered pseudo-scientific, Marx was reportedly challenged even when attempting to explain the epistemology of his own scientific endeavours (Fay, 1987). The concept of critical theory has therefore evolved over time, influenced by many philosophers and social theorists (Abbot et al., 2005; Agger, 1998; Kincheloe & McLaren, 2008; Polit & Beck, 2004; Scrambler, 2001).

Critical theory has sought to examine social order, draw attention to the issues that oppress its members and offer alternative ways for people to function in more satisfying ways. The positive aspects that create opportunities for change may be hindered if a false consciousness exists within the members of that society. Whilst enlightenment and emancipation remain central tenets of critical social theory (Polit & Beck, 2004), in the endeavour to create change and transform social order, enlightenment alone may not achieve the goal of transformation and ultimately emancipation.

Given the potential limitation of critical theory, it is important to distinguish the difference between critical theory and critical social science as outlined by Fay (1987). It is observed in the literature that key visions of many critical theorists revolved around enlightenment and raising community consciousness in order to bring about political change (Best, 1996; Ogle & Glass, 2006; Olesen, 2008; Polit & Beck, 2004). It is therefore imperative to remain mindful that various aspects of critical theory have contributed to the development of critical social science as it is applied in contemporary research.

It is essential to remain cognisant that critical theory per se was primarily interested in the ‘nature of society’, not the human experience for which critical social science is intentionally focused (Fay, 1987). Critical social science provides a lens through which an increased understanding of the lived experience can be obtained, consequently creating new
possibilities to bring about social change and improve the conditions within a person’s world that lead to opportunities for emancipation (Kilgour & Fleming, 2000).

Whilst critical theories have been criticised for taking an idealistic stance in that they may not achieve equitable outcomes for the oppressed groups it serves to benefit (Taylor, 2007), critical theories aim to generate knowledge that will support marginalised or oppressed groups thereby contributing towards emancipatory outcomes (Berman, Ford-Bilboe & Campbell, 1998; Polit & Beck, 2004). It is critical that:

- to overcome the prejudices that have existed in nursing in the past, it is essential that nursing continues to grow, acquire and further define its body of knowledge as a means to achieve socio-political understanding and change. Critical engagement is a means to knowledge development and emancipation of nursing (Mooney & Nolan 2006, p.245).

Critical social science, according to Kendall (1996, p.20), provides “a framework for examining and critiquing socially unnecessary constraints on human freedom”. Therefore this subsequently works toward exposing hidden and oppressive elements that lay within a hierarchically driven nursing profession that can impede individuals’ health and happiness. It is the emancipatory potential that draws contemporary nursing researchers to apply critical social science as a methodological approach, (see for example Corbett, Francis & Chapman, 2007; Kilgour and Fleming, 2000; McGibbon & McPherson, 2006; Polaschek, 2003; Wilson & McCormack, 2006).

If one considers the idea that theory and practice are interwoven and furthermore, that beliefs are both value laden and socially constructed, then the root of critical theory being that of social change (Hall, 1999) provides a pathway to “simultaneously explain the social world, criticise it and empower its audience to overthrow it” (Fay, 1987, p. 23). These factors separate critical social science from empirical-analytical studies in that it not only seeks to understand a social order, generating description and meaning (Taylor, 2007) moreover, it holds emancipation as its key objective.

Whilst many health care professionals practice within contested work environments, the power imbalances and political injustices can be subtle yet covertly present. Arguably oppressive power relations, often expressed symbolically (Georges, 2005) are imbedded in
a “culture of silence” (Friere, 1970, p.29). As such, nurses’ hope for change whilst potentially transformative, may not lead to complete emancipation (Kincheloe & McLaren, 2008). This may be due to the individual’s perception of powerlessness, being unaware of their submissiveness and subjugated circumstances in which they work, eventually becoming resigned to their marginalised status (Fay, 1987; Friere, 1970). Self-awareness becomes critical to changing the power (Fletcher, 2006; Roberts, 2006). Feeling powerless can lead to job dissatisfaction and increase nurses’ susceptibility to burnout and depersonalization (Manojlovich, 2007).

In order to seek change in the social fabric of nursing and health care, issues such as the imbalance of power, marginalisation and the oppression of nurses must be addressed if positive outcomes are to be realised for nurses and nursing. The future must sustain the hope of creating opportunities for social justice, for nursing and of equal importance, recipients of nursing care.

Power, marginalisation and oppression

The power/politic duo adorns the media as coverage of world events bombards our everyday existence. The concept of power is generally explicit in the public arena however many implicit power struggles exist in social environments and workplaces which reflect the political nature of marginalisation and oppression (Fletcher, 2006; Roberts, 2006). Nursing scholarship has drawn attention to the concept of power associated with marginalisation and oppression, exploring theoretical perspectives (Hall, 1999) and the relationships between power and caring (Falk Rafael, 1996; Fletcher, 2006; Manojlovich, 2007; Trede & Higgs, 2003). It was Kuakkanen and Leino-Kilpi’s (2000) intention to define the concept of empowerment however, to do so required an increased understanding of the essence of power in relation to nursing. The authors have claimed that, within nursing, the concept of power is most often associated with negative overtones, namely authoritative and hierarchical structures with coercion and domination central to critical theoretical standpoints.

When considering the concept of power, it is important to acknowledge that power is a complex process believed to be a life force and an energy that derives out of relationships (Brown, 2002). The perception of power by individuals may vary significantly as its
meaning is unique and context placed. Researching the concept of empowerment in public health nursing work environments, Haugh and Laschinger (1996) applied Kanter’s structural theory of power in their study that involved forty-six public health nurses and ten nurse managers. The findings highlighted that staff nurses perceived their level of power differently to that of their managers, with the staff nurses state of empowerment being significantly related to the amount of power they perceived their nurse managers to have (Haugh & Laschinger, 1996).

The relationship between power and nursing has been subject to many research inquiries. For example areas research has been undertaken: in nursing practice (Cash, 2007; Manley & McCormack, 2003; Manojlovich, 2007;); education (Duchscher, 2000; Harden, 1996); nurse/client relationships (Christensen & Hewitt-Taylor, 2006; Oudshoorn, 2005); and care-giving (Davidhizar, 2005; Falk Rafael, 1996; Lupton, 1995; Scarry, 1999;). Violence and bullying in nursing continues to be considered a major issue in health care (Farrell & Bobrowski, 2003; Glass, 2007a; Hegney et al., 2006; Hegney, Plank & Parker, 2003; Hutchinson et al., 2006; McMurray, 2006; Speedy, 2006a;) and its relationship to job satisfaction and nurse retention remains significant (Hogan, 2005; Trofino, 2003).

Stress and distress related to institutional and cultural disparities bring to the forefront the need to examine unhealthy structures that result in privilege and power (Glass, 2007b). When considering the workplace demands currently faced by nurses, Preston (2002) highlighted the impact that working in stressful environments has on the quality of life of nurses and accordingly, the impact the situation has on recruitment and retention of nurses in the profession.

For nurses, marginalisation and oppression is significantly related to burnout and impaired health (Manojlovich, 2007; Preston, 2002; Taylor & Barling, 2002) with violence and bullying impacting on nurses’ emotional wellbeing (Fletcher, 2006; Hegney et al., 2006; Rose & Glass, 2006b, 2008a). Giddings (2005), who set out to explore cross-cultural experiences of difference and fairness specific to nurses and nursing, concluded “nurses need skills to deconstruct the marginalizing social processes that sustain inequalities in nursing and healthcare” (p.304). It is strongly argued that research exploring the emotional wellbeing of nurses and its relationship to nursing practice can contribute valuable insights into the impact of oppressive environments (Rose & Glass, 2005, 2006a).
Fay (1987) in his seminal work, drew attention to the implicit nature of power and its relationship to critical social science by harnessing the terms: force; coercion; manipulation and leadership as key definitions that reveal the nature of power interactions in our society. Nursing environments have been reported as being “unhealthy” primarily due to the nursing shortages, restructures and a focus on disease, and power politics remain at the forefront for nurses as “healthcare facilities are not gender-neutral; they are strongly patriarchal” (Fletcher, 2006, p.50, 53).

Is it that the negative impact of power relationships in nursing arenas is to continue to render its members marginalised and oppressed, and if marginalisation and oppression are taken as a given as suggested by Hedin (1987) is it probable that, by raising the consciousness of the oppressed group members, emancipatory outcomes can be achieved? Critical social science provides a substantial lens to examine the power systems that perpetuate marginal behaviours, hinder social change and potentially impact on healthcare outcomes.

According to Huntington and Gilmore (2006) nursing is a political activity in which nurses’ are highly active within and hold considerable power within it therefore nurses need to effectively engage in the underlying political game. However the nature of power dominance in nursing is of most significance as it has the potential to impact negatively on nurses’ wellbeing. Fay (1987) asserted, “it is the implicit power of the oppressed which a critical social theory can tap in order to be a practical instrument of social transformation” (p.122).

Most significantly for transformation to be achievable, acknowledgment and understanding of the situations that seek to marginalise and oppress individuals and groups is crucial. For marginalised groups such as: women, culture, health, sexual orientation, race and class Hall (1999) suggested that it is the socio-political process within those communities that brings rise to vulnerabilities, strengths or resilience. In addition to the marginalisation and oppression experienced by many women, Glass (1998) stated that for women and nurses, their experience of oppression is akin to a double whammy as they are marginalised and/or oppressed due to their gender and by virtue of their status in health care.
Many contemporary nurse scholars have supported the argument that women and nurses are oppressed and/or marginalised to various degrees within the health care system (Fletcher, 2006; Glass, 2000; Glass & Walter, 1998; Hegney et al., 2006; Luck, Jackson & Usher, 2006; Rose, 2002; Roberts, 2000, 2006; Rose & Glass, 2005, 2006a, 2006b). Furthermore, Harden (1996) suggested that being positioned in a marginalised situation could hinder personal and professional growth and limit the value of the nursing experience. The value of nursing practice is one of crucial importance to the nursing profession however, a perceived invisibility exists thus further perpetuating nurses’ marginal status.

**Visibility and invisibility**

The absence of recognition and action to bring to the forefront patriarchal dominance in nursing environments has the ability to render the valuable work that nurses do as invisible. In Australia the professional needs of Australian nurses are not being met and this is negatively impacting on nurses’ performance (Takase, Maude & Manias, 2006). Furthermore, there exists a plethora of scholarship acknowledging the unique and diverse roles which nurses undertake in clinical nursing practice, for example see literature in community nursing (Annells, 2007; Bert et al., 2008; Brookes et al., 2007; Davy, 2007; Goodman et al., 1998; Jarvis, 2005; Kemp et al., 2005; McGarry, 2003; Parkinson, 2006; Rapport & Maggs, 1997; Rose & Glass, 2005, 2006a; Rout, 2000; SmithBattle et al., 1997).

The perception of some nurses is that their nursing work is unacknowledged and regarded in community nursing as invisible (Falk Rafael, 1998; Goodman, 2001; Luker et al., 2000; Rose & Glass, 2006; SmithBattle et al., 1997). It has been suggested that such views may be attributed to stereotypical perspectives on aging given the greater part of community nursing clients are aged (Goodman, 2001; SmithBattle et al., 1997). Consequently the marginalisation of those nurses working with aged clients is juxtaposed to nurses delivering high technological/advanced nursing skills (SmithBattle et al., 1997) with increased value being placed on the “technical rather than on caring” (Fletcher, 2006, p.51).

In addition, it has been hypothesised that nursing work is not invisible due to lack of acknowledgement, but moreover, the invisibility results from not being noticed by administrators, physicians, other nurses and the public (Liaschenko, 1997 as cited in
David, 2000). David (2000) also drew attention to the concept that nurses engage in a process of self-deception that “[i]s found to be a central organising concept of professional and service delivery organization that perpetuates professional mediocrity, limits freedom of thought and action, and preserves the borderline status of nurses” (p.83).

Acknowledgement and validation of the diversity and excellence within nursing practice is essential if nurses are to work toward overcoming marginalisation and oppression in a hierarchical and male dominated health care environment (David, 2000). As Penz (2008, p.298) argued, exposing the invisible nature of community health nurses’ palliative care work could be the first step toward “valuation, validation, and mutual support”. Critical social science presents a theoretical framework through which nurses can become agents for change however, demanding visibility requires nurses to feel safe to speak out about their experiences that render them silent.

**Silence/voice; horizontal violence/bullying**

It has been my personal and professional experience of feeling silenced as a woman and nurse. Equally I have witnessed oppressive group behaviours such as horizontal violence and bullying within the workplace. Both of these situations/experiences have reinforced my decision to apply a critical theory in this research. My intention was aligned with Fay (1987) when he outlined the need for critical theory to be a “practical force … an enabling and motivating resource” (p.29). It was my intention that by working with the community nurses, as both participant and researcher, that enabling could be realised through processes such as reflection, storytelling, feeling supported, valued and validated in the sharing of meaningful experiences.

Supporting community nurses to speak openly and of free will about their workplace experiences contributes valuable insights into issues that have rendered their voices marginalised and moreover, creates opportunity for positive change. Critical social science is a vehicle through which all participants’ voices can be heard inclusive of my own as participant/researcher. Furthermore whilst remaining cognisant of the sensitive nature of the research and the potential vulnerability of the research participants, I aimed to “seek and make space for the voices of nurses, encourage and support their voices, their issues
and ideas, including what was often not publicly voiced, with the promise to publish their voice and issues as faithfully as I could” (Ogle & Glass 2006, p.122).

I am of the same opinion as Scarry, (1999, p.423) who stated that, “oppressed nurses equal oppressed nursing care”. Whilst the dominance of medical discourse is of prime concern, nurses inter and intra disciplinary relationships are indeed complex. The power politic is most commonly illuminated through oppressed group behaviours such as aggression, as in horizontal violence and bullying. The horizontal violence was believed to stem from the inability of the oppressed to “revolt against the master” rather than, as it has often been interpreted, as “a characteristic inherent to the nature of oppressed groups” (Roberts, 1983, p.23). However more recent studies of oppression in nursing (Fletcher, 2006; Roberts, 2006) and nurses resilience, hope and optimism (Glass, 2007a), brought to the forefront the harmful nature of horizontal violence and the empowering strategies utilised by nurses to improve wellbeing and transform their oppressed identity.

Roberts (2006) highlighted that ineffective communication, passive aggressiveness and the silencing of nurses voice/s were significant issues that continued to be intrinsic within nursing oppression. Australian nurse researchers reported that horizontal violence and bullying had been strongly entrenched in the nursing culture having resulted in “profound harm” for many who are targeted (Hutchinson et al., 2006, p.228). Moreover, workplace violence was perpetuated within organizations characterised by ‘a culture of acceptance, or fear of retribution’ (Speedy, 2006a).

Speaking out against oppressors is fraught with challenges and can result in various degrees of vulnerability. Vulnerability can be the catalyst for positive change leading to increased resilience for nurses (Glass, 2001; Glass & Davis, 2004) yet, vulnerability also was believed to increase the risk of harm, leading to states of physical, psychological, emotional and spiritual ill health (Hall et al., 1994). Whilst inquiring into the gender politic within nursing, David, (2000, p.88) explained that “most nurses shrink from the challenge of taking a firm stand because they have seen those who speak up become disenfranchised for their courage, and they are fearful”.

The fear of nurses speaking freely in the workplace can result in increased tension between the nurses and other intra-disciplinary team members. Disempowering measures
taken by oppressors, such as non-supportiveness and intra-disciplinary hierarchical structures (Daiski, 2004), ensure the voice of the outspoken nurse or nurses is/are silenced resulting in a perpetuation of bullying and horizontal violence which continues to sustain the cycle of nursing oppression.

This may result in the oppressed group member ‘speaking in two voices’, that is, what the nurse may articulate in potentially ‘unsafe territory’ may differ to that which would be voiced under circumstances that are deemed ‘safe’. These juxtaposed positions can result in feelings of seclusion/inclusion; dishonour/honour; vulnerability/resilience; and/or disempowerment/empowerment.

The feminist literature depicts the silencing of women as a phenomenon that perpetuates the oppression of women (Fine, 1992; Glass & Davis, 1998). In the research with rural community nurses Davis (1998) concurred that:

[t]he unspeakable is complex. It is shrouded in the silence that women and nurses keep. Generally nurses and women do not rock the boat by breaking the silence over personal situations and/or the way in which they are constrained by oppressive structures (1998, p.113).

Researchers have highlighted that the challenging health care environments in which many women and nurses practice, have lead to states of disempowerment and silencing (Glass, 2001; Roberts, 2000; Rose, 2002). Women nurses who experience feeling silenced in their workplace clearly illustrate marginalisation and oppression. In order to break their silence or ‘speak out’ (Glass, 2000) nurses must feel supported and safe (VanderPlaat, 1999) by what Glass (1998) described as a ‘process of becoming’. Glass’ model depicted the transition through which women nurses were able to move from a state of silence to one of de-silencing and ultimately reach empowered states wherein they reclaimed their voice/s.

Researchers strongly contend that women’s voices are not effectively heard or validated (Burns & Walker, 2004; Davis, 1998; Glass, 2000; Rose, 2002) yet these issues remain “central to feminist qualitative research enterprise” (Kitzinger, 2004, p.126). Therefore it can be strongly argued that a theoretical framework that addresses the notions of silence and voice are extremely significant to the future of nursing. As Searle et al (2004, p.138) asserted:
Women’s voices are a key resource for feminist qualitative research – but what we make of these voices, how we understand their relationship to women’s ‘experience’ and women’s ‘reality’, is a complex and contested issue.

Drawing attention to the structures and power relationships that inherently subsist in nursing is critical to the sustainability of nursing as a profession. A significant issue in the process of affecting such change is to raise the consciousness of people whose lives are enmeshed within an environment of marginalisation and oppression. One way to address this is to make visible the oppression and examine the power relationships that lead to disempowerment (Manojlovich, 2007).

With a commitment toward political emancipation, both critical social science and feminisms embrace key tenets that seek to bring about social change to oppressed groups such as in nursing. What follows are discussions of those emancipatory tenets namely: consciousness raising and enlightenment; and, empowerment, transformation and emancipation.

**Emancipatory tenets:**

**Consciousness raising and enlightenment**

It has been argued in nursing that “our thoughts and beliefs in turn influence our self-image, our self-image influences our actions, and our actions determine our performance” (Fletcher, 2006, p.51). The notion of consciousness raising holds strong links with feminism and nursing and was an awareness raising technique adopted by the women’s movement. The consciousness raising concept was to be applied to enabling women to consider de Beauvoir’s (1972) process of ‘becoming’ where it was argued that ‘one became a woman rather than being born a woman [and that] women were no longer objects of study by psychologists and other so called experts, but became experts and authorities on their own experiences’ (Cheek & Rudge, 1994, p.59). The dialogue related to ‘becoming’ continues to be highly significant for women, particularly those who continue to experience the ongoing consequences of oppression. In recent times, de Beauvoir’s process of becoming was extended to contemporary nursing when Glass (1998) explored the dialectical relationships that university women nurses experienced. Glass argued that the women participants in her research held a strong desire to be heard. Accordingly, their eventual
shift from feeling silenced to becoming de-silenced and eventually reclaiming their voices became “integ rally linked to raising of consciousness and development of one’s self-esteem” (1998, p.277).

Consciousness raising, also known as the process of enlightenment (Fay, 1987) is a way toward liberation and ultimately emancipation. Critical theory provides an epistemology that sets out to explain why people feel frustrated and discontented, why they perceive their social order as they do and furthermore why change will not occur if they maintain their perception of themselves and the social order. Critical theory also offers alternative ways of conceiving their reality providing a new lens through which their socio-political world is viewed (Fay, 1987).

In addition to the benefits of applying a critical social science perspective, feminism affords women with an additional lens that focuses on issues that are gender specific whilst aiming to address the imbalance (Racher, 2007). In nursing, Roberts (2006) argued that despite the many contributions made by nurses, their optimal potential in the health care system has not yet been reached. Consciousness raising considers the patriarchal influences that devalues nursing and caring as women’s work and thus nurses have a means to view the political influences that impact upon them as women and nurses. Nurses currently positioned in a hierarchy of power and dominance has been described as “self-deception… that perpetuates professional mediocrity, limits freedom of thought and action and preserves the borderline status of nurses” (David 2000, p.83).

For people to move toward states of empowerment and ultimately emancipatory outcomes, an awareness of their socio-political position must be realised. Development of a raised consciousness creates possibilities to expose practices that may have previously been obscured in nurse’s lives. However moving forward is not without risk as it resists the norm of acceptance of ‘what is’, thus challenging the oppressed group members to disrupt the status quo, which can lead to further marginalisation. Moreover, the challenge is made greater when the historic culture of nursing is considered. For instance, “at the root of organised nursing oppression is its history of hospital apprenticeship with its long-time struggle for equality in paternalistic medicalised health care systems” (Scarry 1999, p.423).
That notwithstanding, acknowledgement and understanding of the nurses individual and group encounters provides a window of opportunity through which to examine the inequity of power relationships, patriarchy and the dominant forces that inherently impact upon women’s lives (Ruangjiratain & Kendall, 1998).

Subsequently, critical paradigms aim to critique the social structures and dominant paradigms that impose ideologies that result in marginalisation and oppression to both individuals and groups. Raising the consciousness of women and nurses can result in empowering states providing them with opportunities to speak out about their experiences and subsequently move toward positive emancipatory outcomes:

The full potential of consciousness raising for the politicisation and ultimate emancipation of nurses emerges when critical consciousness raising allows for the acknowledgement of otherwise invisible structural constraints operating on nurses, and makes visible the power/knowledge axes embedded within contemporary nursing practice (Cheek & Rudge, 1994, p.63).

Work environments are typified by competition and struggle (Rose 2002) with such experiences resulting in states of disempowerment and silencing (Glass, 2001; Roberts, 2000). The disempowering experiences must be acknowledged as unique to each woman and moreover, strongly aligned with each person’s socio-political position as both woman and nurse (Roberts, 2006). This notwithstanding, the road toward creating positive change for all women is significantly associated with the vocality of their individual voice/s, whilst at all times remaining mindful of appropriate representation of their accounts (Kitzinger, 2004; Olesen, 2008). Supporting and validating women to speak out and be heard is essential in the process toward empowerment, transformation and emancipation.

**Empowerment, transformation and emancipation**

Empowerment is a concept that is synonymous with nursing, critical social science and feminism and “seems likely to provide for an umbrella concept of professional development in nursing” (Kuokkanen & Leino-Kilpi, 2000, p.235). Yet when women and nurses experience the ‘double whammy’ of oppression (Glass, 1998) this results in a lack of empowerment embedded within a culture of negativity, patriarchy and authoritarianism (Kuokkenen & Leino-Kilpi, 2000).
The perception of empowerment by nurses in the profession was reported to be significantly related to nurses’ health and wellbeing (Glass, 1998; Rose, 2002; Rose & Glass, 2006a, 2008) and moreover was strongly associated with job satisfaction and better client care (Manojlovich, 2007). The importance of perceptions related to power and empowerment are significantly relevant to nurses and nursing particularly if the consequences lead to states of false consciousness thus impeding the potential for transformation and emancipation. Haugh & Laschinger (1996) highlighted the perceptions of nurse empowerment in their research with public health nurses and their managers. Both groups of nurses perceived their job related power to be lower than that of their counterparts. Furthermore, the staff nurses perceived that access to empowering structures such as “opportunity, information, support and resources” (Haugh & Laschinger, 1996, p.42) also being less than their managers perceived them to be. When nurses perceived their position as empowered, the outcomes of job satisfaction and nurse retentions are increased (Trofino, 2003). This supported the argument by Manojlovich (2007) that there are compelling reasons to empower nurses as perceived powerlessness can lead to burnout and depersonalisation. With a focus on empowerment, the potential to positively impact on relationships and outcomes in the health care profession is made possible.

When examining power and empowerment in nursing, a critical perspective is said to be “explicitly definable, stimulating and inspiring” (Kuokkanen & Leino-Kilpi, 2000, p.241) providing a theoretical vigour that seeks freedom through awareness and understanding. Nursing scholars have explored the concept of empowerment across the discipline and the important connection it holds to numerous aspects such as patient care (Christensen & Hewitt-Taylor, 2006; Kendall, 1996; Oudshoorn, 2005); workplace practice (Haugh & Laschinger, 1996); job satisfaction (Hogan, 2005; Kuokkenen et al., 2003; Trofino, 2003) and education (Fulton, 1997; Harden, 1996).

When considering empowerment in relation to nurse leadership, environment and professional traits amongst hospital nurses, Fullam et al. (1998) highlighted accountability as a key issue for the empowered nurse who is responsible for direct patient care, supporting the findings of Haugh and Laschinger, (1996) as noted above. The researchers argued that nurses must value their work, have a willingness to provide the full scope of clinical practice and furthermore, have the ability to engage as an equal member of the
interdisciplinary team. However, the authors outlined a critical point when they agreed that, “in order to move into a fully empowered position, professional nurses need mentoring, education, awareness of political activism opportunities, and networking skills” (Fullam et al., 1998, p.254). Roberts (2006) added reflection, support, insight and connection as important processes to support nurses’ move to empowerment. Consequently, feeling enlightened or having reached a point of raised consciousness is an antecedent to reaching states of empowerment.

Empowerment was conceptualised by public health nurses as “an active, internal process of growth that was rooted in one’s own cultural/religious/personal belief systems” (Falk-Rafael, 2001, p.4). I would argue that empowerment can act as the compelling force that sets in motion a fluid and unique process aimed to enlighten through exploration of the inequity/s experienced by the individual and/or group member/s, subsequently creating an environment in which positive change may potentially take place.

Empowerment is consequently a dynamic process, and self-reflection and introspection are critical aspects required within an empowerment process. Such elements have roles to play in nursing and in the development of self-understanding, as they provide for a greater depth of examination regarding “personal beliefs, attitudes, motivations, strengths and limitations” (Eckroth-Bucher, 2001, p. 32). Self-reflection enables nurses to explore their perception of power and individual state/s of empowerment. The process of self-reflection is considered a tool for “revealing the relations of dependence hidden behind relations… [and] is the road to freedom from institutions” (Czarniawska, 2004, p.76). Applying the process of self-reflection can lead nurses to a raised level of consciousness and moreover, assist nurses in meeting the challenges they face in clinical practice (Taylor, 2004). Self-reflection is a critical element in the process toward enlightenment and thus if practiced by nurses, has the capacity to increase their potential to achieve emancipatory outcomes. Empowerment within the milieu of nursing practice must therefore be examined quite broadly remaining mindful of the nurses’ individual and unique process of self-reflection and its significance to professional practice. Freire (1972) warns that reflection without action is meaningless, whilst reflection with action equals praxis, thus being a forerunner to liberation and emancipation.
For praxis to be achieved an increased understanding of empowerment from the nurses’ unique perspective remains essential and is particularly relevant to the future of nursing practice and thus professional development. The nursing scholarship revealed valuable insights into nurses’ understanding of power and empowerment, see for example Daiski, (2004) and Fulton, (1997). When examining the research by Fulton, (1997), the project identified unequal power relations as having a significant impact on a nurse’s confidence and self esteem resulting in states of disempowerment. Similarly, Daiski, (2004) found that nursing relationships infiltrated by intra-disciplinary hierarchies and mutual non-supportiveness resulted in nurses also feeling disempowered. Such subjugated relationships in contemporary health care practice will arguably result in continued wounding to nurses, that ultimately can infiltrate through to client care (Rose, 2002). The concept of empowerment creates endless possibilities for personal and professional growth and, with that in mind, a raised awareness of and a willingness to address such troubled relationships in nursing, is an important step toward achieving emancipatory outcomes.

Nurses must be supported to participate in actions and decision making processes that have equality as a key principle of the power relationship thereby enabling them to realise their individual and collective “strengths, resources and abilities to make changes in their personal and public lives” (Mason, Backer & Georges, 1991, p.73). Racher (2007) believed that for people to feel empowered they should be able to predict, control, and participate in their environments. Within an emancipatory framework, feminist research aims to challenge the silencing of women’s voices (Burns & Walker, 2004; Searle, 2004) and seeks to “empower all women and address issues that can make a difference in the quality of life for all humans” (Parker & McFarlane, 1991, p.66). As a participant/researcher of the present community nursing study, I assumed my position to be one of equal authenticity, non-hierarchical and one that supports, motivates and enables consciousness raising in a way that leads to self-empowerment and impending social change.

Essentially, I remain mindful of the dangers raised by scholars such as Fay, (1987), Kincheloe and McLaren (2008); Lather, (1991); and VanderPlaat, (1999) regarding research and empowerment, in particular the focus on empowerment being something done ‘by’ the liberated ‘to’ or ‘for’ the unliberated thus posing the question “How do our very efforts to liberate perpetuate the relations of power?” (Lather, 1991, p.16). Brown, (2002, p. 15) suggested “empowering self and others promises to be a way to heal broken trust and
fractured relationships with nurses”. It is argued that empowerment is a process focused on travelling alongside another (Lather, 2007). Critical emancipatory research therefore aims to raise awareness of the forces that can limit an individual or group’s capacity to make decisions that affect their lives (Kinzelhoe & McLaren, 2008). Kuokkanen and Leino-Kilpi, (2001; 2000), noted that the empowerment ideology had been progressively embraced as the conceptual framework for the development of nursing. The researchers reported that nurse empowerment was dependent upon various environmental factors and individual qualities that were inclusive of morality; integrity; expertise; orientation and sociability. The writers concluded that “[e]mpowerment is a process steered by personal values and endeavours as well as by environmental factors. An empowered nurse possesses those qualities which make possible high self-esteem and successful professional performance and progress” (Kuokkanen & Leino-Kilpi, 2001, p.273).

The concept of empowerment is complex and is contextually based and therefore reflective of individual and unique understanding and explanation. When considering the emancipatory framework being applied to this study with community nurses, I remained aware that empowerment remains an integral notion in the implementation of primary health care practice and that community nurses’ complex role/s contend with such issues on a local and broader community level within their daily practice. However, community nurses hold multiple subjective positions; the availability of those subject positions reportedly are limited by historic and discursive influences (Carberry, 2001).

It was my intention to enable nurses to ‘speak from their heart’ and share stories of their own individual and unique experiences, related to their provision of palliative care, that were meaningful to them. It was anticipated that by providing opportunities for their stories to be heard in an environment encompassed by emotional safety, that opportunities for empowerment and emancipation might be realised. I remain cognisant of the belief that “no one is ever completely emancipated from the sociopolitical context that has produced him or her” (Kinzelhoe & McLaren, 2008, p.409). However, empowerment and emancipation are dynamic processes that when visioned through the lens of critical and feminist epistemologies, provide opportunities to expose oppressive environments that hinder personal and professional growth, whilst simultaneously offering hope for a better future. I concur with Harden, (1996, p.32) who strongly asserted that “only then, when our
oppression, both as women and nurses has been recognised, and a critical consciousness achieved, can true humanistic care be given”.

It is important to remain mindful that the process toward emancipatory solutions are not without challenge/s. Raising the consciousness of participants to a point at which acknowledgment of oppressive experiences is achieved has the capacity to raise feelings of emotional vulnerability (Glass, 2006; 1998). The current study engages the women nurses in a holistic process toward consciousness raising with the hope that experiencing enlightened and empowered states will lead to emancipatory outcomes. Emancipatory research is a dynamic process as outlined by Henderson (1995) in which enlightenment and empowerment are critically linked to knowledge and advocacy.

Emancipatory methodologies encompass a diverse range of theories including critical and feminist theory and whilst differences do exist on a theoretical level, both are said to “use critique in a contextual, relational approach to uncover and transform oppressive realities” (Fontana, 2004, p.96) and have the central aim to disrupt the status quo with their focus on diversity, marginalisation and the social inequities (Irwin, 2006). However, whilst they both share many concepts, critical theory alone fails to examine more specifically the gender politic that is addressed by feminism. Feminism critiques the personal and the social realms of women’s lives (Henderson, 1995) and explores why women and men are treated differently in our contemporary society (Pritchard Hughes, 1998). Furthermore feminist methodology can be beneficial in raising the self-esteem of nurses as it values women’s voices, ways of knowing and their individual life experiences (Mason, Backer & Georges, 1991). This can lead to “reclaiming and renaming nursing’s experiences and knowledge of the social world lived in and daily constructed” (Speedy, 2006b, p.165). When feminist thought is placed in context with the women’s experiences, the potential exists for consciousness raising and empowerment leading to change and transformation of the nursing profession (Mason et al., 1991). The inclusion of feminist theory in this study was significant as it offered a lens through which the oppression of women could be examined and the many voices of women validated. I will now discuss feminism in further detail.
Feminism

My decision to undertake this research in a feminist framework was relevant to my strong feminist socio-political position. The epistemological and ontological links between my feminist values and nursing research are well situated personally and professionally. Moreover, I supported strongly the assertion that “applying feminist theory in action can result in transforming oppressive experiences considerably which can continue to improve contemporary nursing” (Glass, 2000 p.365).

Knowledge and understanding of complex and oppressive social relationships can result in liberation and freedom for women and nurses and furthermore, foster the process of social change toward personal and professional growth (Cash, 2007; Roberts, 2006). Knowledge is power, and empowerment is a critical component in the process towards emancipation. For emancipatory outcomes to be realised, women and nurses who occupy dual positions of oppression, that of being a woman and the other of being a nurse, must be provided with opportunities to address the socio-political inequalities that endeavour to exploit and oppress them (Lutz, Jones & Kendall, 1997) and in so doing, hinder their personal and professional development.

There have been a number of feminist theoretical approaches that have advocated for women’s rights and committed to improving women’s positions in society, thus there is no one feminist theory, rather an array of feminisms (Speedy, 2006b; Ramazanoglu & Holland, 2003). Feminisms have a critical role in nursing research as they provide a specific lens through which to examine the patriarchal domination that factors into the marginalisation and oppression of women and thus, leads to the silencing of women’s voices. The contribution that feminism makes to nursing has been argued strongly by Speedy (2006a, 2006b). In her earlier work on feminisms in nursing, Speedy claimed that: “feminism has a great deal to offer nursing, since it provides an analysis of the causes, dynamics and consequence of oppression” (1988, p.49 as cited in Leach, 1998, p.73). In her more recent work on gendered culture, Speedy (2006b, p.168) continues to argue, “such challenges are part of that which the feminisms seek to contribute to the nursing profession”. Therefore, it is strongly argued that the application of a critical feminist analysis has the capacity to enrich nursing knowledge and benefit the future of nurses and nursing as a profession. I will now discuss feminist theory.
Feminist Theory

As a critical social theory feminism offers a political agenda focused on women’s oppression and supports a philosophical base that values both women’s experience and women’s voice(s) (Lather, 2007; Ramazanoglu & Holland, 2003). Feminist research makes “gender, politics, emotions and exclusionary practices visible in knowledge production” (Ramazanoglu & Holland, 2003, p.39).

As noted earlier, many scholars have argued that feminist theory is a collection of theories (Abbott et al., 2005; Burns & Walker, 2004; Fontana, 2004; Pritchard-Hughes, 1998; Ramazanoglu & Holland, 2003; Speedy, 2006b; Taylor, 2007;) dated as far back as the early 1600s in the era of feminist Florence Nightingale (Chinn & Wheeler, 1985; Holliday & Parker, 1997). Feminism is a social movement that was defined by Chinn and Wheeler, (1985, p. 74) as “a world view that values women and that confronts systematic injustices based on gender”. Such a world-view is by no means unified, as it has been argued that “feminists do not agree on the ways in which we can explain women’s subordination or on how women can be emancipated, or even what constitutes oppression” (Abbott et al., 2005, p.27).

Feminist theory aims to examine the experiences of women in society in context to their multiplicitous socio-political positions and is underpinned by three major premises as outlined below by Glass, (2000, p.355):

- Women are oppressed with patriarchal societies.
- The personal is political; that is, there is a direct relationship between social change and political action.
- Consciousness-raising processes are fundamental to an understanding of women’s reality.

It is important to point out that women experience oppression on various levels and in multiple ways, or in other words, ‘there is no universal “woman’s experience”’ (Hall & Stevens, 1991, p.17). Women’s diversity is such that not all women would share a belief that their social world is infiltrated by oppressive conditions (Glass, 2000). It is indeed the challenge of feminism to raise the consciousness of oppressed individuals and/or groups in order to support them in the endeavour to action socio-political change for the better. The
goals of feminism are therefore “at once scientific and profoundly political” (Hall & Stevens, 1991, p.17) and conclusively emancipatory.

**Feminism or feminisms?**

In the discourse on feminism it is most frequently articulated in the singular, however as Glass, (2000, p.357) emphatically stated that there is no solitary feminism, that in fact “feminism is feminisms”. The conclusion is drawn on the basis that multiple theories typify feminist philosophy to the point of complexity. Nonetheless, feminisms all share the same mindset for social critique, albeit differing in what they may name is the primary characteristics of women’s oppression. Marxist/socialist, liberal, radical, poststructuralist and postmodern are examples of theorists (Taylor, 2002) who have all been influential in the development of feminisms. In ‘Speaking feminisms and nursing’ Glass (2000) discussed at length the three waves of feminism, acknowledging the intellectual insights that scholars had brought to the discourse since the early 1900s and paid tribute to those endowments that informed contemporary feminist thought. Table 3.1 below summarises the key points as outlined by Glass, (2000, p.360-362).

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**Focal points of first wave feminism (late 1800/1900s)**
- The lack of material benefits and production for women.
- The right to vote.
- The viewing of women as objects.
- Women as victims of mistaken social knowledge (eg women should not be ‘thinking’ people and have a voice.
- Women wanting to be self-determining, enlightened and sexually liberated.

**Focal points of second wave feminism (1960/1970s)**
- Challenges to patriarchy by focusing on issue politics.
- Strong belief in the ‘personal is political’.
- Putting beliefs into political action.
- Consciousness-raising groups.
- The belief that patriarchal power is visible and also invisible.
Types of second wave feminists and their associated main issues

- Liberal - equality.
- Marxist - capitalism/class.
- Radical - transforming patriarchy/male power-over interactions.
- Lesbian - recognition of sexual orientation and rejection of male desire.

Focal points of third wave feminism (1990 -)

- As a result of the gains of the second wave such as consciousness raising, social change and political action women’s oppression is less overwhelming than feminists have previously argued.
- Women are subjects as well as objects and can be active participants in their communities and agents for change.
- Individual women’s experiences are unique and different to each other.
- Uniqueness and difference cut across and are existent within race, class, sexuality and spirituality.

Table 3.1 Focal points of the three waves of feminisms (Glass 2000, p.360-362)

Each of the feminist waves as outlined in table 3.1 focused on the rights of women, as women’s ontology remained submerged under the patriarchal influences that sought to marginalise and oppress their position in society. The first wave focused on equality and women’s rights. Obtaining the right for women to vote was a major milestone for women during this early period. Again the central issue for second wave feminists remained the equality of women. Feminists challenged the patriarchy in order to make oppression visible and worked toward raising the consciousness of all women. Feminists during the second wave centred their political activity in various directions with a strong emphasis in the belief that the personal is political. In addition Glass, (2000, p.361) pointed out that the second wave feminists also “turned to feminist social and psychological theories to understand their ways of being in the world”. Their united focus was on the visibility and invisibility of women’s oppression in particular on the overt and covert nature of the power that men had over women. The third wave from the 1980s to the present also known as “contemporary feminism” (Glass, 2000, p.363), has developed by viewing feminism through different lens’. Patriarchy with its links to women’s oppression remains central during the third wave, however feminists of this era now encompass poststructural and postmodern thoughts (Glass, 2000). Philosophically these feminists value and validate the notions of difference.
and diversity and moreover, believe that women’s experiences are all unique, individual and contextual.

Highlighting the evolutionary process that has influenced contemporary feminist thought over time provided me with an additional depth of epistemological grounding. The mutual threads of all feminisms relate to the positions of women in the social world with a focus on oppression. In feminist methodology, critical to the research process was ensuring that the principles that underpinned the feminist premises noted above remained at the forefront of the inquiry.

**Feminist principles**

As a feminist researcher it was essential throughout the research process that the principles, which underpinned the premises of feminist inquiry, be actioned. I remained mindful that feminist research could be characterised by “complexity and controversy” (Olesen, 2008, p.315) and that all the women nurse participants in this research had individual, unique and contextually based experiences. The outcome for the participants as women nurses, for myself as researcher and for all women nurses who may benefit from the study, would be reflected by the manner in which the research was undertaken. This research process focused on consciousness raising and opportunities for empowerment, transformation and emancipation of the participants engaged in the research and myself as researcher, at all times ensuring congruence between feminist epistemology and ontology. The principles within feminist research were best explained by Glass, (2000, p.366) when she argued that the aim of feminist principles was to:

> [t]ransform oppressive experiences for women by demonstrating, by action, acknowledgement and valuing of women’s personal and professional experiences, whilst simultaneously allowing women their own voice and [original emphasis] validating their contributions.

The fundamental principles associated with feminist research relate to the valuing and validation of women’s subjective experiences, that women experience oppression, and that there is a desire to create social change through political action to improve the position of women (Abbott, Walace & Tyler, 2005; Ramazanoglu & Holland, 2003; Pini; 2003; Speedy, 2006). Polit and Beck asserted, “feminist political approaches are similar to critical theory
research but the focus is sharply on gender domination and discrimination within patriarchal societies” (2004, p.265).

However, in addition to the principles outlined by Glass, (2000) there were many sub-principles that remain critical to feminist understandings of women’s oppression, Glass (2000) arguing that it was “the inherent subtleties and the depth of women’s oppression” (Glass, 2000, p. 367) that needed to be recognised, valued and validated as meaningful experiences. The sub-principles adapted from various scholars by Glass, (2000, p. 367) are outlined in table 3.2 below.

- Creating emotional safety in working environments.
- Working together collaboratively.
- Recognising the complexities of women’s voice(s).
- Validating differences of opinion and subsequent growth from conflict.

Table 3.2  Sub-principles of feminist research

The principles that have been outlined in table 3.2 highlight critical issues related to the features of feminist inquiry and will be addressed in more detail in the discussion on research methods later in this chapter. For now I would like to discuss emancipatory research, more specifically feminism in relationship to contemporary nursing.

**Emancipatory research, feminism and nursing**

The relationship between contemporary nursing and emancipatory research is significant and it provides a framework through which the profession of nursing can develop. Whilst Chinn and Wheeler, (1985) had highlighted the obscurity of such a relationship in regards to nursing, Burns and Walker, (2004) asserted that over the past three decades feminist inquiries have had a significant impact on key methodological ideas. Expanding further, Burns and Walker (2004, p.66) maintained that:

Feminism and feminist research has been at the forefront of challenging the silencing of women’s voices in society and research and in challenging a narrow, gendered kind of science, which cast women in passive and subordinate roles and excluded them from scientific practices by virtue of them being ‘emotional’ and hence incapable of reason. Crucially, feminist research aspires to be for women as much as it is about women.
As discussed earlier, nursing remains primarily a women’s occupation and with women and nurses identified as oppressed groups, feminism and feminist theory can provide lenses through which the oppression can be critically examined. Nurses, nursing and society have largely accepted the domain of medicine to be the dominant entity with nursing expertise subjugated to that of medicine. When considering oppressed group behaviour, the subjugated role of nurses has taken its toll as evidenced by poor self-esteem and self-concept (Walter, Glass & Davis, 1999) and impaired emotional wellbeing (Rose, 2002; Rose & Glass, 2005, 2006b, 2008a).

Moreover, marginalised group behaviour has also led to acts of horizontal violence resulting in “profound harm” for many who are targeted (Hutchinson et al., 2006, p.228). Although horizontal violence has been discussed in greater length previously, I feel it is important to re-emphasise that workplace violence has been further perpetuated within organisations that have been characterised by ‘a culture of acceptance, or fear of retribution’ (Speedy, 2006a). The existence of violence and oppression in health care environments has been well documented in the literature (Davis, 1998; Glass, 2003; Ogle & Glass, 2006) with researchers supporting the call for “methodologies that seek to address the inequities within nursing whilst simultaneously valuing the illumination of human experience” (Carryer, 1995, p.180-181). Social injustices persist and violence continues to remain problematic in health care environments and, as a result, continue to impact on the wellbeing of nurses. In fact McMurray (2006, p.v-x) contended that:

[t]he insidious nature of violence challenges nursing as a caring profession; at times, overwhelming our private and professional lives, distracting our pursuit of gender equality, and violating the very notion of a civil and just society… only when all people have a right to speak for themselves, a right to dignity, a right to work safely, in equitable conditions will we be able to declare ours a socially just society’.

The social construction of gender is central to feminist methodologies, sharing a commitment to examining the role patriarchy plays in relation to women and women’s experiences (Burns & Walker, 2004). According to Bloom, (1998, p. 139), “women are hierarchically placed below or subsumed by men” and it is the power that is associated with male dominance that feminist researchers seek to address and subsequently redress. Harding (1991) suggested that gender is constructed socially, culturally and historically and it is feminist philosophy that remains opposed to those systems and ideologies that are
male defined and systematically oppress women (Chinn & Wheeler, 1985). In contemporary nursing practice feminist theory provides a means of addressing issues that culturally are patriarchal such as the power traits of strength, aggression and independence valued and identified as naturally masculine. Power has been critically linked with male supremacy and is seen to be central to patriarchal culture (Falk-Rafael, 1997). In nursing, patriarchal power and dominance are examined as socially constructed ideologies and as Chinn and Wheeler, (1985, p.75) emphasised that if:

[w]e in nursing open our minds to values and possibilities that lie beyond patriarchal thinking, we can begin to see relationships between nursing and feminism and can use feminist insights to derive new meaning for nursing.

Applying a critical feminist methodology to the present research with community nurses made provision for an epistemology that was collaborative, reflective and dynamic, supporting the women nurses in this study to openly share stories about their life world experiences. I believed that the potential to develop a transformed professional identity could be realised provided that the researcher was fully engaged in assuring strong philosophical epistemological/ontological links that were maintained within the research process.

**Epistemological considerations**

In the present study I embarked on a journey of mutual dialogue in search of meaning behind women nurses’ lived experiences of palliative care provision within their nursing practice, with a focus on stories related to their emotional wellbeing. Throughout that process I attempted to understand and explore the participants’ worldview in order to create possibilities for positive change for the future.

Women have revealed their struggle to establish a sense of emotional wellbeing in their work environments, attempting to overcome situations that resulted in states of disempowerment and silencing (Rose, 2002). In a system that fails to adequately recognise, value and/or validate its most valuable asset ‘the nurse’, it was critical for women to be supported to take positive steps towards balancing and maintaining their own state of emotional wellbeing. Moreover, the emancipatory framework was intentionally designed to value and validate the women’s voices, being true to feminist epistemology, with the
intention of having their voices heard through the dissemination of the research findings. The figure 3.1 below outlines the feminist emancipatory framework that was applied to this study.

Figure 3.1  Feminist emancipatory framework

It was also anticipated that by giving voice to the women nurses in this study, their experiences related to the emotional effect of palliative care provision would be heard and the feminist approach would prove empowering for the women. In addition to being the researcher I was also a research participant, as stated earlier in this chapter, and that position was significant to the research process. During this project I had been a practicing community health nurse who provided palliative care within the community setting and as such, I was able to engage in reciprocal dialogical relationships with the participants.

Engaging with the participants and embedding myself deeply within the research process, provided mutual ground from which to work; our conversations and acknowledgement of circumstances that were clinically familiar helped to minimise any risk of subject/object divide (Fay, 1996). Furthermore, my dual situation along with my strong feminist stance simultaneously supported my endeavours toward ensuring that a non-hierarchical position was maintained during the study. The next consideration related to the research process
was the choice of methods. It was essential that the methods chosen were consistent with qualitative paradigms that are holistic in approach.

**Qualitative paradigm**

Qualitative research methodologies are based on the belief that knowledge is unique and context dependent and consist of practices that make the world visible (Denzin & Lincoln, 2008). Qualitative inquiries value language, emotions and human experience, placing them as central to this research inquiry. “Qualitative research assumes that the researcher is an integral part of the research process” (Byrne, 2001, p.207) Analysis is interpreted through the use of language and the meaning placed on the narrative, rather than on mathematical deduction as in that of quantitative approaches.

Qualitative research values subjective experience with quality and holism considered key principles (Edwards, 2002). Qualitative researchers pay close attention to ensure validity (Koch & Harrington, 1998; Ogle & Glass, 2006) and apply methods to their inquiries that seek to understand women’s multiplicity of positions as a consequence of their oppression.

Ethical considerations remain critical with the relationships that researchers and participants share (Hofmeyer & Scott, 2007; Orb, Eisenhauer & Wynaden, 2001) giving special attention to “doing no harm” to research participants (Roberts, 2002, p.99). This was significant in this study as the nature of qualitative inquiry engaged the participants in a relationship that, at times, created emotional vulnerability; an outcome of sensitive research identified by other scholars (Glass, 2007; Rose, 2002; Rose & Glass, 2005, 2008a). Emphasis was therefore placed on the research being holistic, contextual and valuing of human experience.

Working within a critical feminist framework also promoted collaboration between the women nurses and myself as participant and researcher, thereby placing value on issues such as equality and reciprocity (Webb, 1993). Another critical point is the quality of the data, thus working collaboratively with the women throughout the research process was epistemologically and ontologically congruent with feminist philosophy.
Qualitative methods that are congruent with the research process, seek to provide valuable insights into situations that are specific to local phenomena (Denzin & Lincoln, 2008; Taylor, 2002). In this study, there were the experiences of women community health nurses and their provision of palliative care. Given the research was deemed sensitive in nature, choosing appropriate analytical methods provided an enhanced opportunity to obtain data that was to be deemed ‘rich and thick’ (Davis, 1998) and moreover, set out to gain an understanding of the complex world of palliative care provision through lived experience. What follows is a discussion on the research methods that were applied to inform this project.

Research methods

As the researcher and self-identified feminist undertaking this inquiry, the next step was to ensure methodological congruence between feminist theory and the choice of research methods. Essentially, the methods chosen were to be reflective of the feminist principles as outlined above, and most importantly, were to be congruent with the philosophical underpinnings of the study. The decision was to incorporate two methods, those being: (method one) reflective journaling and (method two) interviews/storytelling narrative emphasising both mutuality and co-participation.

In keeping with feminist research process, an emphasis was placed on the processes of empowerment and transformation (Taylor, 2002; Glass, 2000), with the ultimate goal of emancipation. However, it was critical that as researcher and participant that I remained vigilant and discerning about whose interests were being served (Northway, 2000). I was therefore interested not only in ‘what’ was being done, but of equal importance was ‘how’ the inquiry was to be undertaken (Taylor, 2007). The methods selected for this qualitative study were intentionally non-hierarchical, with a particular focus on giving voice to the women nurse participants.

With reflexivity in mind, the research methods that were chosen for this study, involved reflective journaling and interviews/storytelling. What follows is a discussion of the methods aimed to enhance awareness of the reflective process that proved to be an effective tool within feminist inquiry. I will begin with method one, reflective journaling.
Method One: Reflective Journaling

Reflective journaling was implemented to bring into consciousness my thoughts, feelings and behaviours related to this research and has been advocated by scholars as notable strategy employed to promote reflexivity (Northway, 2000; Walter, Davis & Glass, 1999). Journaling enabled me as researcher/participant to explore meaning through both reflexivity and intersubjectivity as outlined above, allowing myself as researcher to become fully immersed in the study (Glass, 2000). Also the reflective journaling process provided a forum for critical dialogue, essential to the entire project and therefore a method embraced by feminist scholars.

The reflective journaling was also engaged as a means to have my voice as researcher/participant made visible and my reflections accordingly offered as valuable analytical data that formed and informed the research process. Furthermore, the journal was utilised as a self-healing strategy, enabling me to address any emotions that arose from the sensitive nature of the study. Therefore, reflective journaling acted as a tool for therapeutic conversation (Glass, 2007).

Applying an intersubjective approach also produced an increased depth of analysis related to all aspects of the research, whilst simultaneously openly presenting my analysis and placing me “on the same critical plane as the researched, leaving the researcher open to critical scrutiny from the readers” (Bloom, 1998, p.148). My aim was to apply reflexivity across all phases of the study and I found journaling particularly beneficial. My journals became my close companions, sharing critical dialogue and subjective thoughts, attempting to make meaning of situations that required further analysis. I chose them for their unique designs, their versatility and strength. Usually A5 in size and aesthetically pleasing, the journals were most often selected for their inspiring verses that lined the coloured pages.

The journals, one at a time, accompanied me everywhere, even in the dark of night, so I could ensure my reflective thoughts were transcribed in the moment, rather than dependent upon memory to recall my inner feelings and contextual data. The deep emersion required in the data collection and the analysis phases meant the journal became a valuable reflexive tool.
The following is a journal excerpt that was composed following a visit to a healthcare centre where I had arranged to meet with a community nursing team regarding this research. I had sent the research information and consent forms electronically to the Nurse Manager prior to my request to visit and had understood that those sheets had been distributed to the community health nurses accordingly. However, the environment on my arrival was confronting and the following entry highlights my first impressions and subsequent reflections.

*Narrow corridors, walls with ears, eyes watching. I was kindly ushered to the Nurse Managers office to wait. My luggage took position on the chair in the small space lined with maps, papers and policies. A quiet discomfort reigned within me so I stood alone observing the team activity that was mostly shielded by mobile screening. Desks butting desks, confidentiality limited, voices merging into inaudible song. I felt an underlying tension that remained aloof. Greeted with a warm welcome I was conscientiously escorted to the meeting room. My time was brief yet animated. Attentive smiles throughout the crowded room of nurses yet few questions. That surprised me given their prior knowledge of the study. A softly spoken CHN accompanied my departure. Quietly and quickly I was to learn of the disharmony and the power issues that infiltrated the environment. My feelings of tension were validated, reflected in the brief conversation we held. The situation was complex, vulnerability infiltrating the team, reluctance to speak was revealed. It was the silence that spoke the loudest.*

**Method Two: Interviews/storytelling**

**The Interview process**

In qualitative research, interviews are deemed to be one of the most common methods of data collection (Byrne, 2001; Wellard & McKenna, 2001) as they value the human experience and enable participants to provide stories that are meaningful and subjective. In feminist research giving voice to women remains a central tenet.

The interviews applied to this research were semi-structured incorporating open-ended questions. The choice of method was congruent with feminist inquiry at it sought to value and validate the unique and diverse experiences of the women participants. It was argued by Drew (1997) that meaningful lived experiences were generally understood implicitly in
the first instance however, as participants recalled their past encounters and moreover, shared their subjective reflections through the process of storytelling, explicit understandings could be developed that subsequently created new meaning.

The interview process was undertaken over a fifteen-month period allowing for travel between rural and urban areas of New South Wales. The majority of the interviews “resembled a conversation between friends” (Davis & Taylor, 2006, p.201). However on one occasion I admit to feeling as if the interview was a clinical skill undertaken with proficiency that required clinical grading. I worked hard to soften the atmosphere, to draw meaning from the stories that were initially related about other team members. That was a challenge I pursued to the completion of the interview.

The interviews all took place by mutual agreement in places that were deemed ‘emotionally safe’ by the women. The chosen venues included community health centres, cafés and private homes and whilst I emphasised my preference for a private and quiet space to record our conversations, the locations chosen by some participants were at times less than optimal. Issues that resulted in challenges during the interview process included:

- Interruptions by staff and phones when located in an office space.
- Interruptions by family members when in the home environment.
- Environmental noises whilst in office, home and café situations.

All attempts to minimise potential distractions were undertaken prior to and during the interviews and the situations encountered were addressed collaboratively. However the café interviews proved the most challenging of locations and my journal entries below shed light on two such occasions.

*We met at the café following our earlier phone conversation... Busy road, speed hump, on an intersection, echoic with activity inside, whilst loud and cold outside. We chose outside, a corner table. I was concerned that the recorder would not pick up [our voices] clearly, [and I drew] it closer to her with subtlety during our conversation. I was concerned that others could hear us, the issues were personal and sensitive and full of nursing talk accompanied by laughter and tears. My hand was never far from the recorder.*
We met at the café early over breakfast... the music was loud inside so we mutually agreed to sit outside, alfresco, fabulous! We ordered, chatted informalities and began the interview. We conversed deeply and above the morning ‘songs’ shops opened, people marched and cars roared polluting the morning air. Capturing the dialogue became a real concern for me. I didn’t want to miss the nuances, the quiet reflective moments, the paralanguage and the meanings created. I frequently ‘checked in’ with [the person] to see if she was ok and wished to continue with the interview. We agreed to carry on because time was short.

The oral interviews in this study were intended to be conversational whilst ensuring the participants were engaged in meaningful discussion. The development of the questions took place with careful deliberation to ensure that they were congruent with feminist epistemology and importantly, a reflexive process involving critical conversations with my supervisor and other research scholars raised significant points for my consideration in regard to the proposed questions. For example, as I was seeking to address the issue of healing strategies that the participants in this study may use for self-care, I initially drafted the following question:

- What healing strategies do you use that help you to cope with the emotional work in your professional practice?

The ensuing discussion related to feminist process at the postgraduate seminar highlighted my assumptions that were:

- nurses ‘coped’ with palliative care work and,
- palliative care involved ‘emotional work’.

Following the conversations my assumptions were more clearly thought through. Subsequently, the research questions developed and asked to each participant were:

- To what degree would you consider emotional work to be a component of your community nursing palliative care practice?
- How do you feel about providing palliative care?
- How would you describe your practice as a CHN in palliative care provision?
- Can you discuss any issues or challenges that you experience related to your palliative care practice?
• What does emotional wellbeing mean to you?
• Can you tell me a story related to your palliative care practice that has impacted upon your emotional wellbeing?
• How would you describe the relevance of self-care to your emotional wellbeing?
• Can you tell me a story related to your self-care practices that has impacted upon your emotional wellbeing?
• Are there any other issues that you would like to discuss or anything you would like to expand upon?

The interview questions invited the participant’s to share their unique experiences through the process of storytelling whilst engaging in an intersubjective process. Storytelling is a method favourable with nurse researchers as it makes meaning of the lived experiences that are recounted by nurses (Drew, 1997) and has been argued as “essential to developing holistic practices for all nurses” (Anderson, 1998, p.64).

The questions were open-ended in design and acted as a reference point to begin the women’s reflective journey into their past experiences. Koch (1998, p.1183) argued that “people live stories and in their telling of them, reaffirm them, modify them, and create new ones”. The women’s stories made visible their nursing practice, reflected their personhood as health care providers and drew upon the essence of humanness. As the women’s stories gradually emerged, fashioned within a tapestry of uniqueness and complexity, additional questions were necessary to create opportunities for enhanced understanding of the phenomena. For example, in my interview with Rosemary, the issues of fear and intimidation in the work place were significant, resulting in the following:

• You speak of ‘a culture of fear and intimidation’ could you expand on that please?

Storytelling was an ontological process that sought to be transformative for the participants. Just as the stories gave voice to the women’s lived experiences, the possibility to move from speaking out to actioning change was created. Anderson (1998, p.73) considered that one’s lived experience “is taken into one’s sensibilities, personhood, and life world” and is therefore a holistic process strongly associated with healing and wellbeing.

Storytelling in this study set out to value and validate the participants different ways of knowing related to their palliative care provision. However this method was used to
transform emotions into meaningful text. I am heartened by the attention given to nurses’ emotions encountered in their practice, most often expressed through conversations. As Horsfall asserted, “if nurses value human feelings and consider them to be involved in healing, then emotional aspects of nursing care require professional discussion and sharing, and this indicates that these therapeutic processes need to be researched and documented” (1995, p.8).

Storytelling attempted to engage the women nurses in a process incorporating self-reflection, self-awareness and intersubjectivity. This method provided a forum for the women to be heard within a framework that listened to the many voices used to describe their experiences (Trinder, 2000).

Each interview was electronically recorded on an iPod audio-recorder following University Human research ethics approval and signed participant consent (Appendix Two) The sourcing and selection of participants for this study is an important issue that will be discussed in the forthcoming section on research ethics. In regard to the individual interviews, details related to the interview process are discussed in Chapter Four.

The above discussions outlined the use of reflective journaling and the oral interview/storytelling as the two methods applied to this study. Both methods were deemed congruent with critical and feminist paradigms, attempting to capture the essence of the lived experiences of all participants. The sensitive nature of the inquiry highlighted the need for myself as researcher to be accountable to all those involved in the study plus those who may otherwise be potentially affected by the project. The following discussions relate to the research ethics associated with this study.

Feminist research methods must be selected on their unique value to any given project however, central to that choice must be to enhance credibility whilst ensuring the feminist research processes of intersubjectivity and reflexivity are integrated. I would like to take a moment to discuss those integral processes.
Feminist research processes

Intersubjectivity

Intersubjectivity has been considered a process applied to feminist research to draw together the epistemological/ontological links within philosophical inquiry. Intersubjectivity relates to the ‘ways in which all selves are structured by interactions with others’ (Coslett (2000, p.7) and more specifically, ‘a condition of social life that makes it possible for people to share understandings and expectations with others’ (The Blackwell Dictionary of Sociology, 2000). Coslett (2000, p. 105) draws further attention to the notion of silent intersubjectivity, where the ‘unspoken and unwitting messages of one female body to another’ could be considered of equal importance.

Intersubjectivity involves the “dynamic interplay of self and not-self” (Jackson, 2002, p.30) incorporating the contested experiences encountered in one’s life world, grounded in change, historical relations of experience and transformative processes through which subjective meaning is created (Driver, 2005; Zeedyk, 2006).

The emphasis for feminist researchers is doing research ‘with others’ thereby transcending the subject/object divide that may otherwise occur. Davis and Taylor, (2006, p.200) explained that:

the researcher’s lack of interest in objectivity and an emphasis on intersubjectivity means that the researcher is embedded in a supportive, caring relationship with the participants during the research.

In that way the researcher seeks to break down any barriers that may exist and validate the women’s voices whilst celebrating their shared subjective experiences through which meaning has been created.

In this research my intention was to promote intersubjectivity by engaging participants in a relationship that was based on reciprocity, fostering a mutual understanding of the complexity of palliation within community nursing practice, whilst simultaneously acknowledge the unique and diverse experiences of other nurses. I deemed it critical to sustain a process that was non-hierarchical ensuring attention was given to minimising any
power imbalances that may have existed between myself as researcher/participant and the women nurse participants.

The emphasis on intersubjectivity was intentionally designed to enhance reciprocity and generate meaning within the dialogical exchange whilst at the same time, remaining attentive to the production of “silent intersubjectivity” (Summerfield, 2000, p.105). Silent intersubjectivity refers to the non-verbal messages that may be expressed during mutual communication within the data collection process that would have the potential to influence the “affective intensity for both participants” (Rasmussen, 2005, p.26). Addressing that concern remained critical to my inquiry and was addressed by adopting reflective journaling as a method therefore fostering the intersubjective process (Glass, 2002). Applying a method such as journaling increased my capacity to understand the complex, unique and contextually embedded experiences of the participants, and moreover, was the catalyst through which the essential process of reflexivity could be applied.

**Reflexivity**

In qualitative literature the notion of ‘reflexivity’ has been debated by some researchers as elusive and nebulous (Atkinson & Coffey, 2002; Carolan, 2003; Dowling, 2006), whilst others scholars consider ‘reflexivity’ to be interchangeable with the concept of ‘self-reflection’ (Morrow, 2005). However, with that stated, the use of reflexivity remains central to qualitative inquiry and is of significant importance to feminist researchers in that it endeavours to: “identify acknowledge, and do something about the limitation of the research, which may impair the emancipatory goal of the inquiry” (Fontana, 2004, p.99). Reflexivity requires the researcher to remain aware of ‘self’, attuned to internal and external sources that may influence the research project (Etherington, 2004) and moreover, must remain astutely aware of her own values, beliefs and perceptions whilst attempting to remain open to mutual exchange with participants. The manner in which reflexivity was applied to this study could be distinguished in two ways, through introspection (within the reflective journaling process) and critical conversations.

Introspection like reflexivity, involved a high degree of self-awareness and an unremitting engagement in the processes of self-critique and self-appraisal, both identified by Koch and Harrington (1998) as characteristic of reflexive research. In addition to the reflective
journal kept by me to record my reflexive process, critical conversations took place through a variety of forums, primarily and most significantly, through regular meetings with my research supervisor, presentations at postgraduate seminars and various discussions with academic staff and the research community. Such critical conversations drew attention to my responses, bolstered my avoidance of superficiality and created an environment that optimised critique and analysis. Such a reflexive process served as Morrow (2005) suggested, as the ‘devil’s advocate’.

**Application of reflexivity to critical conversation and reflective journaling**

As the process of reflexivity is a vital characteristic of feminist research (Dowling, 2006), I will now address the way in which reflexivity was applied to this study. What follows does not explore reflective journaling *per se*, but moreover, I have drawn on the following journal entry to illustrate how critical conversations with my Supervisor were crucial to the ontological process.

This conversation arose early in my initial data collection phase, prior to any in-depth analysis of the interviews undertaken. The lead-up to the discussion began following an interview question posed to one participant, asking her if she could share a story related to an experience with a palliative client that had impacted on her emotional wellbeing. The participant now known as Rita, responded thoughtfully, however the shared story focused on a personal situation unrelated to a palliative client. Whilst my initial view during and subsequent to the interview had been that the data would not be usable due to its unrelated context, the opposite was in fact true. What follows demonstrated the importance of the reflexive process, which in this study was applied through critical conversation and reflective journaling. The journal entry begins after reflecting on a phone call with my research supervisor regarding the interviews I had undertaken.

> I phoned Nel today to let her know where I’m at and how the interviews had gone. I love our dialogue as she inevitably critiques what I put forward and is always constructive with her feedback and I always find that really valuable. We discussed the four interviews and whilst I told her that all went well, I highlighted the challenge I faced when interviewing Rita. I told her that when I had asked Rita to share a story related to a palliative client that she had told me a story related to a relative who was not a palliative client. It seemed as though the conversation kept returning to Rita’s personal situation and I know at the
time I felt challenged by that because I thought that a fair bit of the data might not be suitable for use.

During our conversation Nel raised a key question, i.e. what was that situation telling me? I quickly realised that my focus on seeking answers to the research questions had clouded my thought process, I had failed to appreciate that the interview data was in fact, ‘rich and thick’ just as I hoped it would be. Rita’s personal situation had impacted upon her emotional wellbeing and also on her professional practice. The research set out to explore exactly that relationship and that it did achieve! A really positive outcome through another critical conversation! Thanks Nel.

At a later date following my interview with Rita, I presented my initial data findings at the postgraduate research seminar where the issue mentioned above was raised. The discussion between academics and peers alike again reflected the importance of reflexivity and how vital it was for reflexivity to be engaged throughout all stages of the research process. Furthermore, the discussions also reinforced the need for me as researcher/participant, to clearly document such situations therefore ensuring as Hand (2003) suggested, a process that could be deemed open and transparent.

Transparency can bring to light factors that may have influenced the production of this thesis and therefore should be acknowledged and taken into account. It was crucial that the experience I had in the data collection phase was brought to the forefront and placed open to scrutiny. I am researcher and participant, and the research credibility remains dependant upon my ethical stance to expose my research encounters. It was critical to ensure congruency with the feminist epistemological/ontological links, ensuring that that any values, prejudices and bias that may influence the study are fully declared. It was evident that the incorporation of reflexive accounts can enhance the research as new insights are analysed and integrated (Hand, 2003).

**Research Ethics**

Engaging in social science research involving human participants required an increased emphasis on the issues related to ethical sensitivity and research rigour. Conducting
ethically appropriate research with human participants was said to be of increased interest to researchers (Aita & Richer, 2005) with ethical behaviour involving a degree of balance between participant rights, exploitation and the purposes of the research (Seymour & Ingleton, 2005). Furthermore, I was mindful of what Aita and Richer had emphasised when stating that:

“[e]very researcher and professional working in the healthcare field should understand the risks and benefits of their research to the individual and society, and the personal dimension of research ethics… [I]t is imperative that researchers have an understanding of the ethical principles and guidelines that impact the research of human subjects (2005, p.31).”

Scholars have recently explored issues that are particularly relevant to the ethical aspects of qualitative research in regard to nursing (Aita & Richer, 2005; Clarke, 2006; de Laine, 2000; Seymour & Ingleton, 2005), highlighting the moral obligation of the researcher and the ethical concerns related to conducting qualitative research. Whilst this research was conducted with adherence to the ethical standards and conditions set down by the Human Ethics Research Committee, I was mindful that all ethically responsible decisions were to be based on honesty, integrity and attention to human rights (Aita & Richer, 2005). Furthermore, as the research was exploring emotional issues related to palliative care, additional risks of harm existed related to such a sensitive topic thus intensifying the ethical challenges faced. Seymour and Ingleton (2005, p.146) who examined “ethical issues in qualitative research at the end of life” concluded that “the practice of ethically responsible qualitative research at the end of life is neither easy nor clear-cut”. I would argue that this present study also offered unique challenges particularly as end of life issues were central to the study.

The following discussions set out to address the ethical aspects that specifically related to this research and, in so doing, made transparent the ethical conduct of myself as researcher in my efforts toward accountability to all involved. I will begin with the initial phase of gaining ethics approval.
Ethics approval

Prior to conducting this research, I applied to the Southern Cross University Human Research Ethics Committee (SCUHREC) for research approval. This project was granted approval in March 2005 (Approval Number, EDN-05-17, Appendix One). The process ensured that the research was to be conducted in compliance with the conditions of the National Health and Medical Research Council Act (1992) and were inclusive of special conditions as deemed necessary by the SCUHREC. Ethics approval for research involving human participants aims to ensure that the principles of ethical conduct are formally addressed. Accordingly in the SCUHREC application (2004, p.1), the National Statement on Ethical Conduct in Research Involving Humans (the Statement) stated that its purpose is for “the protection of the welfare and rights of participants in research. The ethical and legal responsibilities which researchers have towards participants in research reflect basic ethical values of integrity, respect for persons, beneficence and justice”.

I will now address the ethical issues related to the study.

The participant process

Research Plan

In my ethics application I had proposed a plan that would provide me with a guide from which to work. Starting with the ethics approval, the next stages acted as a guide for me to work into the interview stage, firstly sourcing suitable participants for the study. The details of my plan were to:

- Following ethical approval the information and consent forms will be printed.
- Contact will be made with Nurse Unit Managers of community health centres within NSW (Australia) to seek consent to make contact with potential participants to discuss and/or distribute project information. If possible, an arrangement to attend the community health centres in person to address the staff will be requested.
- Distribution of the information and consent forms will be undertaken.
- After contact is made from potential participants, all questions or concerns raised related to the research will be thoroughly addressed and any points clarified and/or expanded upon.
- Volunteers wishing to participate (until there are ten who have consented) will read and sign the consent form.
• Interview arrangements will be mutually discussed.

Source of participants

It was considered essential that the nurses sought for this study would be drawn from community health centres within New South Wales. All participants were women NSW Registered Nurses, over the age of 18 years and all were involved in the provision of palliative care to clients in their home environment. It was not necessary for the nurses to hold a palliative care specialty qualification, although all of the participants were educated in palliative care, ranging from on the job training to formal qualifications.

Furthermore, as the research intended to explore the emotional wellbeing of community health nurses, it was appropriate that the participants were only drawn from the community health population. With that in mind, a non-probability purposive convenience sampling approach was applied which, according to Roberts (2002), is a method frequently used in clinical nursing research.

Participant selection

Contact was made through the Nurse Managers of community health centres in rural and urban areas that were located on the eastern coast of New South Wales. The geographical focus was chosen for the convenience of accessibility to transport. Initial contact involved email and phone conversations with Community Nurse Managers, followed by on-site meetings. Information sheets and consent forms were distributed electronically through each of the Nurse Managers with original copies distributed in person by me to any prospective participants.

Once the information sheets were distributed, the potential participants were able to contact me at any time, via the details supplied, to address any questions or concerns or arrange a suitable time to meet personally when I was in their area. Upon reading both the information sheet and consent form and feeling satisfied that all issues had been addressed, a mutual meeting time for the interview was arranged.

Initially it was considered that ten participants acquired for the study would be sufficient particularly as the focus was on quality rather than quantity. With in-depth interviews
planned, ensuring ‘rich and thick’ data as Davis (1998) outlined, this was a key aspect of the interview process. With the research information circulated, the responses from community health nurses were rapid. The final number of participants interviewed equalled sixteen, however there were more community nurses who had expressed interest who for various reasons did not participate, including two male nurses. With such a positive response from the community health nurses, it became clear that for the nurses, having the opportunity to discuss their palliative care practice and, more specifically, the relationship it held to their emotional wellbeing, was extremely important.

**Sensitive topic research**

Given the research had the potential to cause emotional distress to the participants, it could be considered sensitive. It was critical to consider the ethical implications involved when exploring such a sensitive topic (Glass 2007; Rose & Glass 2006; Seymour & Ingleton (2005). The research participants engaged in the storytelling process that at times resulted in episodes of distress. As a researcher I remained mindful at all times that my responsibility to the participants involved ‘doing no harm’, an ethical issue related to non-maleficence and beneficence (Hofmeyer & Scott, 2007; Roberts, 2002).

The explicit stories encompassed the human experience of palliative care in the individual life worlds of community health nurse participants and given the emotional issues related to participants’ wellbeing and the stories shared relating to their emotional work, the potential risk to harm was evident. End of life issues such as death and dying and the associated aspects of physical and emotional pain were central components of the conversations openly conveyed. Palliation was clearly a sensitive issue for the participants making the focus on emotional safety paramount for the participants and myself as researcher/participant.

In order to minimise any potential impact it was important to provide an environment that was conducive with emotional safety. That was achieved by mutual agreement with each participant who selected an appropriate place that was deemed safe to them to conduct the interview. The participants were advised that the audio-recording could be turned off at any time during the interview should they request it. The recorder was stopped on many occasions for a variety of reasons, for example, interruptions during the interview by staff,
phone and family and on a few occasions the interview was paused due to distress. On one occasion the recorder was paused for a short while, at the participant’s request, due to the confidential nature of the story she was sharing at the time. The participant stated when the recording was to recommence. I found that many stories were shared pre or post audio-recording, the meaning of which I attempted to capture in my reflective journal.

With the above mentioned noted, I feel that it would be beneficial to outline the ethical considerations that were significant to the study.

**Ethical considerations**

- Ethical approval was granted by the Southern Cross University Human Experimentation Ethics Committee prior to the process of data collection.
- Each participant had the research and interview process verbally explained to them.
- Each participant was given a concise and easy to read information sheet along with an informed consent sheet.
- Each participant was given every opportunity to raise any issue of concern and have any questions related to the research fully addressed.
- Each participant was informed that they may withdraw from the research at any time, without penalty and/or consequence.
- Each participant had been explained the possible sensitive nature of the research and that discussing their experiences may result in a degree of emotional discomfort.
- The participants were assured that the tape recording would cease at any time throughout the interview should they wish to take a break or not proceed further.
- I was vigilant regarding the need to minimise distress however, when the participants showed any signs of distress during the interview I did provide immediate emotional support, remaining empathetic and caring towards their needs and associated vulnerability. If participants required any additional support or therapeutic intervention I would have arranged for them to speak with or make an appointment to see a counselor or therapeutic healer of their choice. I was able to provide the participants with a list of contact numbers relevant to their geographical location, however no participants took up this offer of additional support.
- Follow up regarding their emotional state and need for professional support was
also conducted. Contact details of counselors were made available to each participant although no participant felt the need for additional professional support.

- Each participant was advised that in order to protect their identity that the use of pseudonyms would be used and that all identifying details would be removed. This was a critical issue for a few participants, particularly due to their senior status and therefore identifiable stories involving their practice.

- Each participant was advised that the transcription of the audio-recorded interviews will be undertaken by the researcher.

- Each participant was advised that a copy of the audio-recorded interview would be provided to them to allow them an opportunity to make any comments or changes should they feel it necessary.

Rigour

In addition to the ethical considerations related to this research, it was integral that the interwoven aspect of rigour within this study was thoroughly addressed. Rigour refers to:

The strictness in judgement and conduct that must be used to ensure that the successive steps in a project have been set out clearly and undertaken with scrupulous attention to detail, so that the results/findings/insights can be ‘trusted’ (Taylor, 2007, p 400).

Whilst many scholars have addressed the issue of rigour in qualitative research, (Broussard 2006; Byrne 2001; Dowling 2006; Hofmeyer & Scott, 2007; Morrow 2005), I noted that the concepts applied in the pursuit of rigour varied considerably across the scholarship. For example, specific terms such as validity; reliability; credibility; transferability; dependability; auditability; confirmability; fittingness and trustworthiness were evident in the literature. Morrow (2005) stated that qualitative research from across the various disciplines applied multiple standards of quality. However rigour must be determined in qualitative research by the epistemological assumptions of the study (Taylor, 2002, 2006).

I was also aware that ensuring rigour significantly related to the Researcher’s ability in regard to ‘writing up’ the findings of the study. Scholars believed that providing the reader with adequate representation of the data enhanced its credibility (Broussard, 2006; Koch,
where as Dowling (2006) strongly emphasised the process of reflexivity being of critical importance. Expanding on the ‘writing up’ process, Koch and Harrington, (1998, p.887) claimed that if:

the research product is well signposted, the readers will be able to travel easily through the worlds of the participants and makers of the text (the researchers), and decide for themselves whether the text is believable or plausible (our terms for rigour).

To achieve validity, and credibility I focused on applying a process of rigour that was focused on women’s ways of knowing and a process that validated and valued women’s lived experiences and accordingly I applied the approach in the seminal work of Hall and Stevens (1991). As Taylor (2007, p.401) confirmed “[their] ideas can still act as a validating process for feminist research”.

In particular I focused on specific aspects of rigour such as reflexivity, credibility, rapport, complexity and relevance. In the concluding chapter of this thesis I will incorporate a discussion regarding how the integration of these key issues were achieved throughout this project. With the methodological issues now outlined I will now invite you to read the article that was developed from this chapter. It would be expected that replication of some data will be apparent to the reader however I trust that you will find the paper of interest. Details related to the publication now follow.

**Publication details**


Word count: 5330 (excluding abstract and references)
Journal article removed due to copyright restrictions. (pp. 102-116)

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Full text available online via Academic Search Premier & ProQuest 5000

(Subscription databases)
Summary

I have outlined in this chapter the methodological issues that were pertinent to this study along with the processes and considerations associated with its development. I drew attention to my position as Researcher, making transparent my socio-political position as a feminist seeking to gain insight into emotional wellbeing of women community nurses.

In addition, I explored the concepts related to the emancipatory framework, those being critical social science and feminism. I discussed The Frankfurt School of the 1920’s to contemporary feminism exploring marginalisation and oppression whilst working toward consciousness raising, empowerment, transformation and emancipation. Feminist theory highlighted the characteristics of women’s oppression whilst we travelled through the three waves of feminist discourse only to emerge within the principles of feminist epistemology.

The following discussions highlighted qualitative research, the two chosen research methods and the two chosen research processes. The research process of intersubjectivity and reflexivity were illuminated with examples from my journal entries. I then addressed the research ethics and the process of rigour.

What now follows is Chapter Four, the research findings. This chapter makes visible the complex nature of palliative care nursing and the relationship it holds to community nurses’ emotional wellbeing and professional practice.
Chapter Four

Research Findings:

Creating visibility
Introductory words

In the previous chapter I discussed the methodological issues associated with this study. The aim of this chapter is to present the subjective and multiplicitous experiences of the sixteen community nurses who participated in this study. It is with intention that I acknowledge the women’s differences yet unite their voices consistent with the methodology, and in the hope of creating deeper understanding of their palliative care practice and its relationship to emotional wellbeing. With the women’s stories told, it is anticipated that opportunities will be created whereby many nurses and health professionals will benefit from their collective wisdom (Thorpe & Barsky, 2001).

It is also with intention that this chapter will be written through an emancipatory methodological lens. Data extracted directly from the interviews will be intrinsically weaved throughout, with the aim of bringing the nurses voices to the forefront. In addition, excerpts from my reflective journal will form part of the discussion as these could relate to how I found a participant at the time or what I thought, felt or observed in context with each participant. This process is congruent with feminist methodology and aims to demonstrate the process of reflexivity and inclusiveness of myself as a researcher/participant.

In addition, it was considered necessary to remain mindful that all nurses’ stories are meaningful and valuable. It was my intention to honour all of the women’s individual contributions by maintaining the unique context. In order to achieve a quality outcome, it was essential that I immersed myself deeply within the data with the intent to respond to the research question:

> What are the lived experiences of women community health nurses providing palliative care to clients in a home environment in relationship to their emotional work, emotional wellbeing and professional practice?

This chapter has been divided into two main sections. Section One will discuss the process of data analysis where as Section Two will discuss the research findings. In Section Two, the exploration and analysis of the research findings will be presented under the three main research aims. These are to investigate the:

- concept of emotional wellbeing.
- relationship between emotional work, emotional wellbeing and professional practice.
strategies utilised by the nurses that promoted their emotional wellbeing.

Each aim will incorporate relevant themes and sub-themes. In addition, each aim will include a research paper in the form of a manuscript or published article. One manuscript submitted to an internationally peer reviewed nursing journal is currently under consideration. The other two manuscripts have been accepted, one with minor revision. All details related to each paper will be provided as an introduction. Where a relevant conference paper has been presented, a copy of the power point presentation is added in the appendices section.

Section One: The process of data analysis

Introduction

This section is designed to provide an overview of the process associated with the data analysis. One of the aims of this process was that a transparent process demonstrates accountability, therefore the data has been analysed utilising critical feminist epistemological and ontological processes. This section begins with introductions of the women nurses participants in alphabetical order.

The participants and anonymity

The sixteen women community nurses who gave generously in time and spirit and whose experiences, insights and valuable contributions have informed this study were: Amelia, Anna, Betty, Dee, Haley, Joy, Kay, Lee, Louise, Rita, Rosemary, Sarah, Shae, Taylor, Tishe and myself. Of the sixteen women participants, most had been hospital trained, however several have post-registration tertiary nursing qualifications in community health nursing and palliative care. Eleven of the participants were graded Registered Nurses, two practiced as Clinical Nurse Consultants and three as Clinical Nurse Specialists.

For purpose of anonymity, the exchange of real names with pseudonyms was discussed with each participant. Although some of the nurses were not concerned if their real name was used, to ensure participant protection, pseudonyms were identified for each participant. In congruence with feminist process, the participants were individually asked to
select a pseudonym or alternatively, I could choose a name on their behalf. Most women chose the latter option.

When the choice was left to me, I gave particular thought to a name that reflected my experience of that person. For example, one of the nurses had such an outstanding joyful presence, I chose Joy as her pseudonym. The name Rita, ‘a pearl’ represented how I felt her clients could perceive her as being a real ‘gem’.

The participants were all employed as community health nurses, Clinical Nurse Specialists or Clinical Nurse Consultants. The roles of the specialist and consultant differed in that they undertook additional responsibilities. All of the participants carried considerable client-loads however the specialist and consultant nurses also acted in the capacities of team leaders, educators and mentors. This necessitated careful consideration related to inclusion/exclusion of data during the representation of the findings.

I was aware that some conversations reflected the nurses’ senior status thereby creating an increased risk of identification. For example, I was aware that communication between specialist palliative care teams and community nursing teams were a cause of concern. During one interview I inquired about palliative care referrals. The participant commented:

I actually attend the fortnightly [hospice] meetings and that’s case review. So I get information about potential clients coming our way... I can alert the members of staff that are going to be responsible for that client.

As was the case in many teams, only a senior nurse was authorised to attend the multidisciplinary case review meetings. Therefore to retain anonymity, I intentionally omitted any comments or details that I considered could potentially lead to nurse identification.

After speaking at length with my Supervisor regarding this critical issue and in order to ensure absolute protection of identity (Glass, 2007), pseudonyms were not always used. It could therefore be expected to note in this chapter an example like this:

participants' described needing to "offload and be light hearted" and argued strongly that "you need to talk it out because you don’t want to be taking it
With the nurses now introduced, I will now expand on the process undertaken to thematically analyse the data. This involved a number of stages and will begin with engaging the data.

**Engaging the data**

As I immersed myself in the data from the first interview, I recalled the words of Burns & Grove (1997, p. 527) who asserted that ‘qualitative data analysis occurs concurrently with data collection rather than sequentially’. With that in mind, I focused on a process involving listening, reflecting and journaling any thoughts or themes that arose. Along the way, I also remained mindful of listening to what was ‘not said’ equally to what ‘was said’ (Glass, 2003a; Pannowitz, 2007). It was the covert data such as the women’s emotions, pauses and silences that Glass (2003a) pointed out was also significant for the Researcher to analyse.

The women participated in this study with a refreshing openness and had the intent to share their stories in the hope of making a difference to nurses and nursing. I regarded each interview as meaningful and information rich (Eddy & Mellalieu, 2003; Patton, 2002). Capturing the richness and making visible their untold stories created a great sense of enthusiasm for the participants and myself as researcher.

What follows is a discussion on the process I applied during analysis. I will begin by introducing the use of my reflective journal as a critical component of the process.

**Reflective journaling**

I have always considered journaling to be a valuable tool for self-reflection and have found this process extremely beneficial in relation to my nursing practice. The journaling process became a key component in the development of this research. This method involved recording my thoughts, feelings and reflections related to the study, as well as its use as a therapeutic tool for exploring my own feelings related to the experience - this is a method valued by feminist researchers. Glass (2001, p.174) affirmed in her research with nurse academics that, “[i]t was therefore my own therapeutic conversation, and a way of de-
briefing with myself particularly when the research raised issues of emotional pain”.

Commencing from the first interview, I spent time documenting my initial reflections. These would relate to how I found the interview process, the participant and/or thoughts I had related to the overall interview content. For example, following my interview with Kay I reflected:

Kay walked a tightrope, balancing between love and commitment for her palliative role with feelings of frustration and low self-concept. Kay perceived her ability to meet the client’s psychosocial needs as inadequate. Her smile was confident and sincere yet behind the smile lay insecurity and vulnerability.

Whilst reflective journaling formed a critical component of data analysis there were a number of other stages engaged throughout analysis that would work to identify the emerging themes. I will begin with the interview process.

The interview process

As stated in Chapter Three, the interviews were recorded on an iPod digital recorder. In addition, the digital timing feature on the iPod made it easy for both the participant and myself to monitor the interview progress. Being mindful of the time spent with the participant was essential, as participants had consented to an interview of approximately one hour. Whilst attention was paid to time, most interviews extended, with participant consent, to approximately one and a half hours in length. Only one interview lasted in excess of two hours.

There were times when disclosures were made during the interviews that were not recorded by request. Primarily this was due to the sensitive nature of the disclosure. Following one occasion I reflected:

Whilst I have explained the processes taken to ensure anonymity in the study, this is the second time a participant has requested the recorder to be turned off. Whilst I respect the nurses’ decisions, I became increasingly aware of the underlying vulnerability related to potential repercussions. The health service’s power is reinforced and the oppression of nurses continues.
That notwithstanding, disclosures were occasionally made after the interview had ended when the iPod was turned off. On occasions with consent, we recommenced recording in efforts to capture the disclosure. This did not always capture the true essence of the associated emotions that related to the story. I believed that was due to the interruption of conversational free flow resulting in a loss of natural thought process. Following each interview, I spent time to write my reflective thoughts or at times recorded a voice memo if time was short. All interviews and voice memos subsequently needed to be uploaded onto my computer.

**Digital data upload and member checking**

All interviews could be directly up-loaded onto my computer as WAV files. Whilst the chosen digital data collection method was extremely effective, the process was not without its challenges.

In my early research travels, I had one day that was particularly busy with visits to health services and interviews. Having previously being involved with interviewing research participants I felt a ‘healthy nervousness’ whilst simultaneously feeling prepared. The day went well and positive outcomes were realised. However at the end of a long day negotiating new geographical territory, speaking with many people regarding the research, and participant interviews, I found myself overly tired. After retiring early I awoke once to record a voice memo that had emerged from my sub-consciousness. A new dawn and back to the computer. Data upload was attempted only to experience an iPod system failure. The thought of losing all of the interview data from the previous day horrified me. My journal explains further.

*It was a poor decision not to ‘upload’ before going to bed as my iPod crashed totally this morning. I can’t express my disappointment and emotional distress at the thought of four interviews being lost! I phoned Apple Mac for assistance with no success. I made contact with a local Apple IT technician who directed me by phone through a process of re-booting, or ‘rebirthing’ as I prefer to call it. All interviews and voice memos were recalled from the memory and have now been uploaded and backed up on a memory disk. My relief is indescribable!*

With the management issues sorted, future interviews were completed, uploaded and files
created readily for transcription. It was also necessary to convert each WAV file to Mp3 format and then burn to CD to enable its return to participants for member checking. Accompanying the CD was a personal note of thanks and a reminder that they were free to make any changes, additions, clarify or exclude data if they felt it necessary. Follow up contact with participants was made several weeks later by email and/or phone and no changes to the interview data was requested.

**Transcription**

I deliberately chose to transcribe most of the interviews with use of the digital transcription program ‘Express Scribe’ however due to time limitations, I also employed an experienced research assistant to transcribe a small number of interviews. Whilst the research assistant was required to transcribe verbatim, I chose to selectively exclude irrelevant data during the process. Data excluded incorporated non-relevant chatter and interruptions during the interview. Informal conversations before and after the interview were often extremely valuable and thus included.

I was careful to also include any short or extended pauses, reflective moments and emotional responses that accompanied the text. I also adopted this process when reviewing the transcriptions undertaken by the research assistant, as I was aware of the importance of my recall back to the time of the interview. All transcripts were saved in the express scribe program and then copied, pasted and re-saved as a word document for ongoing use.

**Word document to working table**

The next step involved creating a second copy of the word document. This document became a working file. I replaced each participant’s name with the pseudonym. The new working document was then converted to a workable table. The design of the table was adapted from a process created by a fellow doctoral student (Pannowitz, 2007).

The working table incorporated the research question and three specific aims in the table heading. This was to ensure that the focus of analysis remained congruent with the research aims. Columns were created to store the interview data, the research aims and additional headings considered congruent with the methodology. This process did undergo
Final working table

The key document used in the analysis process was the final working table. Once the interview data had been copied into this table, the next step was to read through the data and eliminate any unnecessary words or phrases such as ‘umms’ or irrelevant data that may have been left in during transcription. Attention was given to ensuring that any pauses, inflections or non-verbal emotion were retained to capture the reality of the moment.

The next stage involved listening to the digital recording simultaneously with the final working table. This enabled any corrections to be made and omitted data to be included. Moreover, this process provided a further opportunity to listen for any cues or themes that may arise. The merging of audio and written text blended to enhance analysis, thus my reflections of the data could also be documented and emerging themes recognized.

In addition to the final working table I also created similar working tables that were aim specific. This involved copying and pasting data from the main table to each of the specific tables. In terms of analysis, I found this process not as effective as I had hoped as it isolated data with the potential to lose context. On completion of this process, I then considered the challenges associated with working electronically or on hard copy during analysis.

Working with hard copy

As I found working with large electronic documents very difficult, I subsequently printed off a hard copy of each participant’s working table. The hard copies allowed me to be surrounded by data, moving forward, flipping back and making relevant comments as the analysis process continued. Highlighters were an invaluable asset during to this process, enabling manual colour coding of each specific aim within each of the hard copies.

The colours were bright and aesthetically pleasing. Working with one participant at a time, I read each transcription thoroughly, highlighting the specific aims in a different colour. As I read, listened and reflected there became a clear overlap of data bringing attention to the interwoven nature of the concepts. I wrote comments and thoughts as they arose in the
adjacent column. This process was repeated for each participant. The comments were transcribed onto a new participant working sheet for further analysis. Further analysis and emergent themes were transcribed to another individual working sheet.

**Final thematic analysis**

Once each participant’s individual analysis had taken place, the combined themes were put onto a working sheet for final thematic analysis. The themes that emerged now represent the findings. It is important to note that some themes did overlap. All efforts were made to represent those themes in context with the participants’ individual experiences, a process designed to minimise potential or actual discrepancy.

It was also critical that the themes were represented in context to the three specific research aims under inquiry. As noted above, there will be occasions when the reader can expect to identify an overlap due to the interconnected nature of the themes. For example, professional boundaries were discussed in relation to three areas, emotional wellbeing; professional nursing practice and self-care. Therefore some excerpts from the nurses’ stories could be partly replicated, albeit intentional to emphasise specific context.

To summarise the process of data analysis undertaken during this study, I have created a visual representation (figure 4.1). The model holds the participant and interview as the central focus in the process, moving in a clockwise direction through each stage of analysis.
With the exploration of the stages of data analysis complete, I will now introduce the second section related to the research findings.

Section Two: Exploration and analysis

Introduction

I have divided this section into three sub-sections to align with the three research aims as outlined in the introduction to this chapter. This section brings together the emergent themes incorporating excerpts from each participant’s interview. The intrinsic weaving of participant excerpts throughout these discussions is intentional to bring to the forefront the
women’s voices. What follows initially in figure 4.2 are the three aims, main themes and sub-themes that arose from the study. I then address the findings related to each aim.

**The concept of emotional wellbeing**

- Feeling balanced
- Feeling out of balance

**The relationship between emotional work, emotional wellbeing and professional practice**

- Demanding
- Rewarding
- Comfortability

**Strategies utilised to promote emotional wellbeing**

- The importance of self-care
- Palliative care affecting emotional wellbeing
- Counteractive self-care strategies

*Figure 4.2 Research aims and themes*
Research Aim One: The concept of emotional wellbeing

Preamble

It was found that the participants strongly identified a relationship between emotional wellbeing and the concept of balance. These themes and sub-themes that are central to this discussion are outlined in figure 4.3 below and subsequently discussed and analysed. In addition a developed manuscript from these findings, submitted for publication completed aim one.

![The concept of emotional wellbeing](image)

Figure 4.3  The concept of emotional wellbeing, main themes and sub-themes

Findings

The nurses in that study related emotional wellbeing with a mind, body, spirit connection, stress and having an inner sense of balance. From my data analysis I found that the participants’ emotional wellbeing was multifaceted and immersed in the unique subjective experiences related to the their personal and professional worlds. The nurses identified the interconnectedness between their emotional, physical and spiritual selves yet not all nurses associated emotional wellbeing directly with nursing practice. Lee believed that:

> [e]motional wellbeing [has] got nothing to do with nursing. I think my emotional wellbeing is tied perhaps to ... the connection to my friends, the fact that I need animals in my life and music, so its about those things that make me tick, that make me then go and connect as a nurse.
I began by asking participants the question “What does emotional wellbeing mean to you?” Some nurses responded with initial reservation. This indicated that emotional wellbeing could be a concept usually reserved for clients or others, yet not necessarily for themselves (Rose & Glass, 2005). To overcome the perceived difficulty, I posed a second question that explored the nurses’ experiences of feeling emotionally unwell. It was anticipated that if the nurses could explain feeling emotionally unwell, this may also provide them with insight and a raised consciousness into their understanding of their feelings of wellbeing.

The nurses’ stories of wellbeing were directly and/or indirectly related to the notion of balance therefore the theme ‘feeling balanced’ was used to depict nurses’ experiences of wellbeing. Whereas the equally important theme, ‘out of balance’ captured that complexity of feeling emotionally unwell. The two key themes will now be discussed.

**Feeling balanced**

The work/life balance (Ablett & Jones, 2007, Hawksley, 2007; Barnard, Hollingum & Harfiel, 2006) has been a subject of interest for many scholars having a strong focus on the impact of work-related stress. For the nurses in this study, balance was intrinsically linked to their wellbeing and their emotional, physical and spiritual health. Four key aspects were evident and subsequently placed into sub-themes, these were:

- Being self aware
- Coping
- Feeling spiritually enriched
- Setting boundaries.

**Being self-aware**

Self-awareness has been long associated with reflective practice and is considered “fundamental to the formation of therapeutic relationships in nursing” (Stein-Parbury, 2005, p. 51). A strong degree of self-awareness enabled the nurses in this study to respond to situations and challenges they encountered in a very humanistic way. Participants revealed that increased self-awareness was integrally linked to their emotional wellbeing and it is this level of personal knowing that Stein-Parbury (2005) suggested enhances nurses’ ability to be authentic, congruent and open to the clients in their care.
There was also a strong awareness of the personal/professional nexus evident as nurses spoke of their need to spend time with family and friends, remain objective in clinical practice and work with empathy rather than sympathy to reduce the emotional drain. Nurses engaged in reflective practice for professional growth and also for personal healing. Thorpe & Barsky (2001) found that self-reflection was a positive step toward the healing of nurses in their study.

Whilst there were varied reasons that necessitated reflective practice, it was apparent that there was a strong link between reflective practice and the nurses’ emotional wellbeing. Rosemary spoke of feeling challenged as she found herself working with oppressive management whilst having the additional responsibility of mentoring less experienced community nurses. Rosemary clearly identified the need to remain aware of her own emotional wellbeing. To achieve wellbeing, Rosemary believed that she had to:

[k]eep things in balance... I think that you get to a point where you are reasonably experienced and you can reflect back on your practice and think, I did this and I did that, that's their choice... [and] I had no control over it [and] I did the best I could. So I think sometimes I go home feeling very sad but I think it's probably better that I feel a bit sad [rather] than just walk out the door and not think anything. Then I should give it away!

Like Rosemary, it was clear that awareness of professional limitations and strengths in nursing were significant to many of the nurses’ sense of wellbeing. Whilst nurses acknowledged their wellbeing could be an “up and down journey” they also had a strong self awareness of their own humanness and accepting that they can only do the best they can in regard to client care. Lee believed that:

[J]ust knowing that you do your best and knowing sometimes that no matter what you do you can’t change an outcome always. Its not about walking away from it its about recognising it.

For most participants self-awareness was critically linked to their ability to recognise their emotional state and to create change as needed. These empowering positions not only highlighted the value participants placed on their own wellbeing but moreover, identified a
raised consciousness regarding their human potential. For example the participants believed that emotional wellbeing involved:

Being aware more than anything. Being aware of what state you are in and recognise what you need to do about it. And it’s not what anyone else can do for you, you have to do it yourself [Dee].

Identified emotions, being about to see them and understand them instead of seeing them and reacting with them and putting that on to other people. It’s an ownership thing. You’ve got to find out why you’re feeling like that instead of putting it onto someone else close to you [Kay].

Having an awareness of yourself and knowing what your limits are and doing stuff to look after your own wellbeing. So it’s about looking after yourself [Taylor].

**Coping**

Researchers have reported that the emotional demands of palliative care placed nurses at risk of stress and distress impairing their ability to cope (Wilkes et al., 1998, Wilkes & Beale, 2001). A few nurses in this study raised coping as a strategy to address the challenges of palliative care. The relationship between coping and the nurses’ emotional wellbeing were highlighted in comments such as “the way I cope”. Personal empowerment was achieved as nurses reflected on their ability to cope with the emotional challenges related to palliative care. For example, Joy’s voice gained confidence when she expressed her thoughts on emotional wellbeing:

I feel like I can cope with it. I’ve never been in a situation where I’ve said, “Oh look I can’t do this, I just can’t cope”. So I guess that’s the way I cope with it... and knowing I’ve got a really strong support.

The ability to cope was also dependent on the socio-political context in which the nurses were positioned. For example, nurses casually employed had less opportunity to know the clients well and at times found themselves in emotionally challenging situations. Rita shared the emotional challenges she faced when caring for two clients with a diagnosis
similar to a close relative. When asked what emotional wellbeing meant to her Rita began by stating it was:

[how I cope with different situations... Every situation is different as well, and there are things that you can relate to more [than others]. Like at the moment because [my relative] is not well then [coping] is an important issue for me.

The link between Rita’s personal ordeal and her clinical practice made evident the challenge she faced when working with palliative clients. Rita believed that as a casual community nurse it was her responsibility to “fill in” where needed, regardless of the emotional demands. To counter balance the emotional impact, Rita took a philosophical approach stating that she:

[always had a very supportive family and [has] always been of a very happy disposition. And I think it’s what you put into life as opposed to the cards that life deals you, I think that it’s how you deal with things.

*Feeling spiritually enriched*

Several of the participants drew strong links between their emotional wellbeing and their spirituality. Spirituality can have differing meanings depending on the individual’s life view and values (Barnett, 2006) yet having a sense of spirituality has been regarded as being helpful to nurses working in the oncology and palliative care sectors (Vachon, 2003).

Spirituality for the participants related to their way of being in the world. Nurses’ expressed the need to feel happy, energetic and joyful while some nurses sought solitude, needing to feel peaceful and being able to enjoy their day. The relationship between balance and the mind, body, spirit was raised by Cox (1997) who believed that the more balanced one was, the more potential for reaching out one would be. For the participants, feeling spiritually enriched incorporated feeling grounded and balanced. Relationships with family, friends, animals and music were all identified as important to the participants spirituality and wellbeing. Sarah’s spirituality was revealed as she reflected on her inner feelings. She remarked that her emotional wellbeing was when she had:

[a] lot of energy (pause) I feel like engaging with people, I feel positive and enthusiastic about life and feel just generally healthy and well.
And following a long and reflective pause Sarah added:

Yeah all those things, and that I feel well, happy, settled and energetic.

The nurses in this study took positive steps to leave work “at work” however the stress associated with palliative care could at times make this process more challenging. Letvac (2006) highlighted that the inherent stress related to nursing, combined with the stress associated with everyday life, has the potential to negatively impact on nurses. Enhancing spiritual growth was one suggestion put forward by Letvac (2006) for nurses to reduce the negative effects of stress.

The nurses in this study were often challenged in their attempts to separate themself from the constant head talk that could impede their wellbeing and subsequently impair their sense of spirit. For Haley being free from ‘head talk’ and having an emphasis on pleasure revealed the significance of spirituality to her wellbeing. Haley maintained that a positive intent was important:

Just being able to be and enjoy your day and not have that verbal chatter going on in your brain about the things that are wrong, because the instant you stop, in comes the verbal chatter and that’s [it].

**Setting boundaries**

Scholars have identified professional boundaries as a way for nurses to traverse the challenges associated with nursing practice. A national framework was first developed for Australian nurses in 1998 (Australian Nursing & Midwifery Board, accessed 1 February, 2008; Sharp, 2007). According to the guidelines there is professional onus on nurses to maintain a therapeutic relationship with clients, yet not only to maintain their own boundaries, but moreover, “to assist colleagues, clients and women in maintaining theirs” (ANMB 2008, p. iii).

Whilst the document guides nurse/client relationships and professional nursing practice, it fails to adequately address strategies to negotiate the challenges associated with therapeutic relationships and reduce the potential impact on nurses’ emotional wellbeing. Holder and Schenthal (2007, p. 29) believed, “maintaining appropriate professional boundaries is everyone’s responsibility” yet balancing and managing boundaries in nursing
practice are not often addressed (Wilstrant et al., 2007). According to Sheets (2001, p. 37) "crossing professional boundaries usually has no harmful effects and may enhance the therapeutic relationship", therefore there must be a distinct difference made between boundary violation and boundary crossing.

When considering boundary issues in oncology and palliative care, these can create challenges due to prolonged contact and close relationships that can develop (McNeely, 1996; Maes, 2003; Shaffer, 2007; Wilkes & Beale, 2001; Wright, 2006). Lillibridge et al., 2000) asserted that professional boundaries must always be negotiated in context with each nurse’s unique circumstances. The nurses in this study identified professional boundaries as being important to their practice and emotional wellbeing, having clear benefits for clients and nurse. Boundary issues were multiplicitous and observed as a complex balancing act (McGarry, 2003) that extended across all areas of their professional practice. Following several interviews and a period of reflection I journalled:

*The complexity of boundaries is intense and extremely context dependent. There is a real dialectical tension between the nurses setting boundaries to care for themselves and blurring the boundaries to care for clients. It is an intimate dance that is hidden from others. If nurses perceive their client’s needs are being met then they appear able to set clearer boundaries however, if their perception is to the contrary, then blurred boundaries are more likely to occur.*

The participants held juxtaposed positions in regard to boundaries in that some nurses set boundaries to avoid over involvement with clients, yet often consciously chose to become over involved. This could relate to the struggle community nurses face in efforts to address the paradox between developing close relationships with clients and family and maintaining professional distance (McGarry, 2003). This was particularly challenging for many nurses, however some nurses such as Taylor, maintained a sense of balance and wellbeing by remaining mindful that “you’ve got to be careful not to befriend [clients]”.

Like previous studies, see for example Canning, Rosenberg and Yates (2007) and Skillbeck and Payne (2003), the nurses in this study also identified risks associated with therapeutic relationships and the potential impact on their wellbeing. The setting of boundaries often related to the identified link between the nurses’ emotional wellbeing and their need to self-care (Barnard et al., 2006). This was evident through the process of self-
validation and the belief of many nurses that “it’s about saying that it’s okay to look after me” [Taylor]. One nurse highlighted the importance of keeping check on her thoughts, feelings and personal needs, validating the importance of debriefing and reflection yet simultaneously setting a boundary around the amount of time spent within the process. Lee explained that at the end of each day she spent time with a colleague, allowing fifteen minutes each for debriefing and reflection thus supporting her efforts to maintain a balance and enhance wellbeing. The emphasis was placed on ending the day on a positive note. Lee stated:

I think what is really important is that you check in how you are feeling [and] what are you thinking and feeling can be two different things... It is important to try and find something that reaffirms who you are, pick out some good points... some positive things.

Nurses in this study also identified the actual and potential risk of taking work home - a concern highlighted by other palliative care nurses (Barnard et al., 2006). This could prove more challenging for nurses who lived and worked in smaller rural communities (Canning, Rosenberg & Yates, 2007; Kenny et al., 2007; Wilkes & Beale, 2001). Whilst this was the case for many of the participants in this study, all nurses were clear about their need to set boundaries to ensure they left work at work to avoid the emotional impact on their wellbeing that could carry over into their home life:

I think that palliative care is one of those things that you could go home and worry about things all night and for me it’s making sure that I go home and leave my work at work. Sometimes it’s not that easy [Amelia].

Whilst leaving work at work was an important factor related to the nurses’ emotional wellbeing, maintaining a balance also involved remaining mindful of the need for setting boundaries to avoid bringing personal life issues into the workplace. Some nurses identified this as a potential risk to nursing practice and ultimately quality patient care. Lee commented:

The thing is how you actually try and maintain the boundaries. If you’re having a bad time in life [then] not to be bringing that to work, although we are human [and] we have our frailties, we can’t all do that all of the time.
Out of balance

As discussed above, there was a perceived sense of difficulty when participants were asked to explain what emotional wellbeing meant to them. As a consequence, my initial response was to alter the question in the belief that nurses could find it easier to identify with the concept of being emotionally unwell. The quick responses supported that belief. Arguably these findings indicate that emotional wellbeing remains culturally marginalised for nurses, yet it is promoted as a core component of holistic care of clients.

That notwithstanding, further exploration revealed that the participants’ associated being emotionally unwell with feeling ‘out of balance’. As the stories unfolded, so did the interconnectedness between the nurses’ emotional, physical and spiritual selves to describe feeling out of balance.

An emotional, physical and spiritual interconnectness

Physical tension, distress, sadness, restlessness and irritability were reported as indicators when feeling out of balance. Problems such as mind racing, sleeplessness and worrying were sustained and some of the nurses were depleted of energy. The nurses relayed stories of how their impaired emotional wellbeing impacted on their personal and professional worlds and on their collegial relationships. Amelia said:

I usually get physical tense... I might jump to conclusions at something, my mind tends to race a bit if I’m upset, so I can find myself drawing conclusions before I’ve heard all the information... I am aware of when I’m becoming a bit stressed. I’m not sure if I can identify the cause or not but I can identify when I am not quite myself.

Anna associated being out of balance with stress and like Amelia, recognised the impact of that on her professional/personal interface. Anna described feeling:

Stressed, restless, angry. Not content, not happy not all the things that you wish you were. Very short tempered... I don't sleep well, I lay awake at night looking at the ceiling and worrying... I am unhappy and very restless.
Like Anna, Shae’s impaired emotional wellbeing also had an impact that affected others. Shae recalled:

> If I’m unbalanced everybody knows it. I talk about [the issue] a lot. I can’t let it go. I’m teary, I’m emotional, I’m impulsive. I say and make rash decisions that I wouldn’t do if I felt balanced which ends me up in more strife… I put myself in the firing line sometimes unnecessarily. I don’t sleep well, I’m anxious. I’m looking for the next thing to go wrong. I come from a real negative base. I am expecting the worst instead of expecting the best. I act like I am a victim when I am unbalanced… it’s a real negative thing.

Many nurses found it difficult to let go of their client-related thoughts after work, thus having an impact on their wellbeing. That hindered the nurses’ capacity to relax, recoup and heal from the emotional challenges of the day. For instance Joy laughed, displaying awkwardness during her disclosure. Joy explained that feeling emotionally unwell related to feeling sad and:

> I can’t stop bawling, or I can’t sleep because of something… I’ve had a lot of sleepless nights thinking about [particular clients].

And for Betty, it meant:

> Sleeplessness (pause), stuff unwind in my head, getting upset… I have to be vary mindful that I don’t discuss how I was feeling about the particular client [with my family] because that is just off loading onto somebody else… The emotional stuff has to be professional not personal [Betty].

Organisational issues and system failures were other contributing factors to the community nurses’ impaired wellbeing. Lee’s frustration and irritability with organisational issues had impacted on her job satisfaction and also her workplace environment. Lee argued that it was not:

> [a] user friendly service, not when it’s under resourced because there is nothing to give [the clients]. So I get frustrated with the systems and maybe I get frustrated with my co-workers… but I think they know I’m frustrated with the fact that I can’t give the care that I would like to give.
It was evident that the concept of emotional wellbeing was multifarious for all participants. Of equal importance was that it was not always discussed with their colleagues. Part of the issue could be that nurses’ workplace environments are not conducive to promoting emotional health and healing, and that results in nurses not feeling adequately supported (Glass, 2007; Hutchinson et al., 2006; Jackson, 2004). Inherent within this, is the issue of nurses feeling unheard. Wishing to have their voices heard could partly explain the enthusiasm of community nurses to participate in this study. I recall my journal note written after a visit to one community health site:

I was invited by the NUM [Nurse Unit Manager] to speak with the team. The nurses were quiet and silence filled the room... Before leaving I was approached in the corridors by interested nurses. Having the research focus on their emotional wellbeing was significant. Nurses whispered unexpected and at times complex disclosures related to the challenges they faced with palliative care and the impact on their wellbeing. I listened, responded and validated, yet simultaneously felt affirmed knowing that this study was significant to them. Yes, your voices will be heard!

It was apparent in my brief encounters with the nurses that not only did they need to be given an opportunity to tell their stories and accordingly feel heard, of equal importance was the process. Reflective processes could be beneficial in exploring the complex issues, raising consciousness and creating opportunities for emancipatory outcomes. Nursing registration/certification demands that nurses comply with professional competency standards which inherently involve reflective practice (ANMC, 2006; Johnstone, 2009). Reflective practice is a key skill and strategy that could enable all nurses to manage their own responses to workplace environments.

Studies have demonstrated that a strong relationship exists between personal/professional wellbeing and professional satisfaction/integration (Glass, 2007, 2008). The benefits of exploring the concept of emotional wellbeing in this study effectively place the nurses stories in context with their professional experiences and personal understanding, thereby contributing additional insights into the wellbeing/satisfaction/integration nexus.
Conclusion

Aim one revealed the findings related to the concept of emotional wellbeing in context to the participants’ palliative care practice. Exploration of emotional wellbeing was found to be a multifaceted and complex concept. Data analysis revealed that a relationship existed between the nurses’ emotional, physical and spiritual health and quality client care. The overarching themes identified from the findings were associated with feeling balanced and feeling out of balance. Whilst the community health nurses valued their palliative care role and found their practice was a source of job satisfaction, juxtaposed positions were evident due to experiences that resulted in stress, frustration and at times not feeling heard in their work environments. Workplace environments were not always conducive to healing and wellbeing, creating a dialectical tension between caring for self whilst caring for others.

From the research findings related to the concept of emotional wellbeing, a manuscript was developed and submitted for consideration in the peer reviewed nursing journal Collegian. An exact copy of the manuscript now follows. The manuscript is presented in “Times” font for the purpose of distinguishing it from other writings and the formatting is in accordance with the journal requirements. Directly following the manuscript will be a discussion on Aim Two of this research, ‘the relationship between emotional work, emotional wellbeing and professional practice’.

Introducing the manuscript

The manuscript entitled: ‘An investigation of emotional wellbeing and its relationship to contemporary nursing practice’ was submitted for consideration to the internationally peer reviewed Collegian in October 2008. This paper was developed from the data that has informed this first research aim. Given the length of the preceding discussion, the reader can expect to identify some content repetition. The manuscript is presented in “Times” font to differentiate it from the main text. Prior to reading the manuscript, I have outlined the manuscript details for your perusal.

Manuscript details


Word Count: 3992 (excluding abstract and references).
Journal article removed due to copyright restrictions. (pp. 142-159)

Collegian

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Research Aim Two: The relationship between emotional work, emotional wellbeing and professional practice

Preamble
The discussion and analysis in this sub-section represent the findings that have emerged through analysis of the second specific aim of the research. It is my intention to make visible what could be regarded as the most multifaceted aspects to the study. Subsequently the manuscript submitted has been accepted, with minor revisions, to *Journal of Clinical Nursing* and follows this sub-section.

The aim, themes and sub-themes are outlined in figure 4.4. This will be followed by an exploration of the emergence of a pervasive interconnectedness between emotional work, emotional wellbeing and professional practice.

Findings
The findings revealed one overarching concept, that being a pervasive interconnectedness between emotional work, emotional wellbeing and professional practice. The interconnectedness was influenced by many factors however, three major interwoven themes emerged, highlighting that palliative care provision was *demanding* and *rewarding*, yet dependent upon the nurse’s *comfortability* within her practice. I will begin the discussions by expanding on the pervasive interconnectedness before exploring the three main themes.

**A pervasive interconnectedness**

Just as the ebb and flow of life creates a canvas of unique experiences, perception of emotional wellbeing for each nurse was also unique. The concept of emotional wellbeing was multifaceted and remained in a perpetual process of fluidity. It was apparent that the participants’ subjective personal and professional experiences influenced their state of emotional wellbeing just as freely as their state of wellbeing influenced their professional practice. Emotional wellbeing was associated with the nurses’ emotional energy. The nurses identified the emotional work related to palliative care referring directly and indirectly to the ‘energy’ required to provide quality care. Interlinked with that was the nurses’ capacity to restore/maintain their energy levels. The degree of emotional energy varied according to the needs of clients, nurses, and the competing demands associated
with nursing practice. The energy expended was therefore dependent upon opposing forces from within self (intrapersonal) and outside of self (interpersonal), subsequently creating a dialectical tension. As a situation arose in practice the nurses’ ability to respond was determined by interconnected elements associated with both intrapersonal and interpersonal factors.

I found the intrapersonal challenges were associated with the participants’ inner capacity to address the presenting issues, for example, the importance the women placed on personal healing and self-care. In contrast, the interpersonal challenges were often beyond their control, for example, lack of available resources due to fiscal restraints. All encounters drew upon the participants’ energy reserves and were interrelated with the participants’ internal/external resources. Each situation was unique and context dependant.

Intrinsic to restoring/maintaining nurses levels of energy was the capacity to promote/enhance their emotional wellbeing through healing and self-care. Nurses inherently applied a variety of strategies that were often implicitly and explicitly expressed throughout their stories. These included taking time to emotionally balance before entering a client’s home, or engaging in more structured strategies such as regular physical exercise. The findings associated with self-care will be revealed in greater detail in Aim Three.

Every participant’s story was unique and explicitly subjective. The stories were encapsulated within their humanity, delicately interwoven by threads of physicality and emotionality. Data analysis demonstrated that the participants’ experiences and reflections could emerge and re-emerge throughout the interviews to represent distinctive points. For example one participant could share a story to highlight the emotional work associated with palliative care practice and, when discussing emotional wellbeing, family dynamics or self-care, may once again draw upon the same story. The various elements associated with the pervasive interconnectedness have been highlighted in figure 4.4 below.
Within the interconnectedness arose three main themes that were interwoven and interdependent. These were: **demanding**, **rewarding** and **comfortability**. The demanding aspects related to how palliative care practice varied. Demands were revealed as an emotional burden and the ability to manage the emotions experienced by palliative clients and their families living with terminal illness. Demands also were the result of the need to enhance relationships, seek support and develop skills and quality client care outcomes. The rewarding aspects of palliative care were revealed as the participants’ spoke of the satisfaction gained from their contributions to care, positive relationships and their aim to make a difference to client outcomes.

Comfortability was interpreted as the participants’ perceived level of engagement in the emotional and psychosocial aspects of client care. Inherent within comfortability was emotional wellbeing. When nurses were comfortable with their skills, the rewards were greater and their wellbeing was enhanced. By contrast, if the nurses lacked confidence in
their skills, their satisfaction decreased and their emotional wellbeing was impaired. Figure 4.5 outlines the themes and sub-themes that will be explored in relation to Aim Two.

The relationship between emotional work, emotional wellbeing and professional practice

- Demanding
- Rewarding
- Comfortability

Figure 4.5 Aim two The relationship between emotional work, emotional wellbeing and professional practice, main themes and sub-themes

Main themes

Demanding

The demands associated with caring for terminally ill clients has been previously identified as extremely difficult, and a cause of stress to many nurses (Henderson, Hanson & Reynolds, 2003). As the participants shared their stories it was evident that palliative care was stressful due to the emotional challenges encountered when caring for clients and family. Relationships were important and the nurse/client relationship was highly valued. Yet these relationships were accompanied by family dynamics and workplace issues that placed unwanted demands on the nurses, and these impaired their wellbeing. This finding supports the earlier work by Mok & Chiu (2004) when they found that the absence of positive relationships with clients was associated with less than optimal outcomes.

The emotional and psychosocial aspects of client care entailed emotional work that required self-care strategies to be implemented. Additional demands were associated with limited time and limited opportunities for education and professional development. Similar findings were reported in a study of nurses working in generalist palliative care. Nurses regarded their challenges as “the everyday pressures” (McDonnell et al. 2005, p.17). Increased workloads and inadequate staffing were found to place extra demands on the
participants’. These findings also concurred with those reported by Grunfeld et al., (2005) and McDonnell et al. (2005). For example, researchers reported that nurses working in cancer care “had a sense of diminished care” with increased workloads being a major source of stress (Grunfeld et al., 2005, p.64). The work environment had a negative impact on the nurses’ wellbeing. Whilst the participants’ roles were demanding, inherent within that were the emotional demands of the nurses. The demands were not identified in context of being negative or involving a misuse of power, moreover, nurses' demands focused on their desire to achieve quality client care outcomes. The participants’ demands were associated with enhancing client and collegial relationships, establishing effective communication channels between professional colleagues, advancing clinical skills and expertise to benefit client outcomes, and to access means of support to enhance the wellbeing of their clients and family, and for themselves. However, whilst the nurses’ role was considered demanding, it was simultaneously rewarding.

**Rewarding**

This theme was developed as the participants shared stories that evoked feelings of job satisfaction. Henderson et al. (2003, p.76) believed that end of life care could be a “valuable and rewarding” role yet advocated for self-care and emotional support. Being professionally satisfied also had a positive impact on participants’ emotional wellbeing. Mok and Chiu (2004) reported that nurses felt enriched by the relationships they developed in palliative care. Many nurses spoke of feeling privileged when caring for clients and family facing end of life. Rewards came from a variety of aspects related to their practice. Of most prominence were the positive relationships participants established with clients, family and other health professionals involved in care. Providing holistic nursing care and making a difference to clients' palliative processes was important. Studies have revealed that relationships in palliative care were established on trust, goals and reflexivity and were associated with giving the clients renewed “revitalised energy” (Mok & Chiu, 2004, p.480). Nurses worked hard to advocate for clients' needs and to ensure a client died a comfortable death with dignity. Participants also felt rewarded if they believed they had been instrumental in making a difference to the life and death journey of clients and family members. Grundfeld et al., (2005, p.67) found in their study that “helping patients and families was a major source of job satisfaction” For participants' to meet the demands they encountered within palliative care practice and attain the rewards, a degree of comfortability was essential.
Comfortability

It was apparent that the participants’ degree of comfortability with providing palliative care varied according to their perceived knowledge, skills, and experience that informed their practice. All participants revealed some level of comfortability associated with the physical “hands on” care, although some nurses identified their desire to develop clinical skills with regular updates. That notwithstanding, the data revealed that the level of comfortability diminished for some nurses when required to provide emotional and psychosocial care. Nurses have identified adequate time and education in terminal care would enhance their ability to provide emotional support to those in their care, but simultaneously identified their own need for emotional support. This could be associated with their level of confidence in this aspect of care.

Scholars have identified challenges to palliative care provision that are associated with nurses perceived lack of confidence dealing with clients’ and families’ psychosocial needs. McDonnell et al. (2002) reported the barriers to include a perceived lack of education and training, workplace pressures and lack of support that include staff shortages and lack of an integrated multidisciplinary approach to care. These were areas of practice that nurses revealed as being challenging, to the point where participants revealed feelings of inadequacy and blurred professional boundaries. Therefore, perceived levels of comfortability were extremely important as comfortability held a strong relationship to client outcomes and the nurses’ experiences of emotional wellbeing.

Interwoven nature of themes

Data analysis exposed the interwoven nature of the three main themes. Whilst palliative care practice could be demanding, the rewards did not always relate to feeling happy or joyful. Moreover the participants’ practice could be associated with feeling satisfied and they had done their best to achieve a good client outcome. Achieving a good client outcome could also be associated with the level of comfortability to address the challenges the nurses faced. Participants had high expectations of their own capacity to provide quality client care. Scholars have highlighted that where death is a daily occurrence, that palliative care nurses are “particularly vulnerable to self-assessments about care of the dying” (Kristjanson, et al., 2001). The findings of this study clearly demonstrated that
emotional vulnerability was present and not specific to the numbers of clients who died in their care.

Whilst there remains an expectation of health professionals remaining “strong in the face of pain, suffering, and death to avoid showing feelings in the workplace” (Henderson, Hanson & Reynolds, 2003, p.74), the essence of our humanity does not refrain from the emotional work impacting on our wellbeing. Henderson et al. (2003) stated, nurses “might feel like never getting attached again just to protect [themselves]”. Therefore the demands and the rewards were plentiful for the participants in this study, however, the integrative factor related to their comfortability to provide care whilst balancing their emotional wellbeing.

McDonell et al. (2002) found that a lack of confidence, support and education resulted in feelings of inadequately managing the care of dying patients. When participants’ perceived a lack of counselling skills for example, this could place extra demand on a nurse. This could result in the emotional demands being greater, the rewards being less and the comfortability far from optimal. The outcome could therefore have a significant affect on client outcomes and nurses’ wellbeing. I have drawn from the data to provide excerpts that aim to highlight the complex and interwoven nature of the themes.

One participant highlighted aspects of palliative care practice as being emotionally demanding whilst simultaneously expressing a state of comfortability with her capacity to provide palliative care. The participant considered palliative care to be rewarding yet acknowledged that palliative care was “highly emotional”:

> It has to be with dealing with people at the end stage of their life... People are very raw. They often talk to you about things they have never spoken to anyone about... So each relationship you have with a client is so different but it reminds me a lot of being a midwife. The moment of birth when you deliver a baby and the last moment before people die, that total vulnerability [Lee]. But to me it is very privileging and very humbling.. I actually really enjoy it.

The complexity between the demands, rewards and comfortability were revealed when participants expressed the challenges they encountered and the emotional impact those events had on their wellbeing:
There have been times with clients that the level of the client’s distress cannot be eased by anything that you can do, and that you as a nurse feel powerless along with the family. [The client] comes home [from palliative care] and they are dying an awful death… There are times when I have felt helpless because I have done all that I can…. You just grapple with being human and having failure [Lee].

I felt myself hating this [person] because [the client] was dying but [the partner] didn’t want [the client] to know… Ethically, I think that’s horrible… I just felt so sad for that [client]… Sometimes you just can’t save the world and I’m okay with that. If I can look back and think I helped that person with [their] shower and [the client] was calm and peaceful, then I think that’s all that matters. That’s my little bit [Anna].

During the in-depth analysis of the interviews, multiplicitous elements emerged that were associated with the three main themes of demanding, rewarding and comfortability. The elements were interwoven and formed, and informed the women’s experiences associated with their professional practice. Together the themes and elements were pervasively interconnected to reveal the strong relationship between emotional work, emotional wellbeing and professional practice. The elements were in a perpetual process of fluidity. In figure 4.6 I have expanded on the figure 4.4 to illustrate the pervasive interconnectedness. Figure 4.6 below provides a colour coded visual illustration aimed to distinguish the themes and interwoven elements. The theme *Demanding* is represented in red/orange, *Rewarding* in yellow, and *Comfortability* in light green.
As identified above, whilst palliative care was demanding it was also revealed as rewarding. Central to meeting the demands and acknowledging the rewards was the comfortability nurses had to provide quality client care. The following discussion expands on these pervasive elements within the themes with data explication.
Demanding

In this theme the participants’ experiences associated with the demanding aspects of palliative care practice will be revealed. The interwoven elements that will be explored are, managing emotions; feeling balanced/out of balance; organisational/workplace issues; interpersonal communication; professional boundaries; education/professional development; emotional energy; emotional support; feeling empowered/disempowered; and professional recognition.

Managing emotions

Managing the emotional responses of clients and families could be extremely demanding for the community health nurses. The impact was often exemplified as participants’ spoke of feeling “emotionally exhausted” and “emotionally drained”. The emotional challenges that clients and family faced were at times described as “heart wrenching” and could result in impaired wellbeing for the participants. Scholars have confirmed community health nurses reports of stress (Wilkes & Beale, 2001). In addition I was mindful of the comments by Dunne, Sullivan and Kernohan (2005, p.372) that “the emotive nature of the experience cannot be underestimated”. This study supported the findings of other generalist community health nurses that their practice was also associated with stress (Wilkes & Beale, 2001; Rout, 2000; Wilkes et al., 1998). One participant affirmed that:

I find it really stressful, palliative, and I know that my colleagues find it stressful too because it’s such an emotionally charged time for the family and patients and yeah, gosh, this is bringing up tears [Kay].

Whilst the participants’ believed that, “you can’t take the personal or the emotional part out of [palliative care] at all”, nurses raised the emotional impact associated with the unknown element when visiting clients at home:

It’s draining and because each day you don’t know what you’re going to find when you get there, even if you ring first, you get there and there is a totally different picture... it’s very unpredictable and you can’t tell... It’s challenging [Dee].
Whilst the participants valued professional autonomy, there were downsides to working alone and/or at a geographical distance that could challenge and impact upon the nurses' wellbeing. Lee affirmed it:

[c]an be hard when you are confronted with a particularly distressing situation when you are by yourself.

As a consequence, participants implemented self-care strategies that would support their wellbeing by preparing for the emotional impact. Anna spoke of how she managed her emotions by preparing before going into a client's home:

You just don't know what you are going to find when you walk in, so I guess I 'steel' myself with every client in a way (long pause) and because you are on your own.

The demands of working with young people and their families clearly impacted significantly on the participants' emotional wellbeing. Nurses grappled with making meaning of the young lives that were being ‘lost'. Kay commented:

At least with an adult you can justify their life... There should not be [children] without a mother, there is no logic to that and she was so distressed, she didn't know what was happening. It was all too quick... That was a really hard one, but the young ones always are.

Caring for clients in the home environment places an importance on getting to know the family members so that collaborative relationships could be developed that would support and enhance client care (Andrew & Whyte, 2004; Kennedy, 2005; Luker et al., 2000). However, scholars have revealed that working with the families can be both rewarding and demanding and that families were a resource, yet at times were also considered to be a burden (Benzein, Johansson, & Saveman, 2004). Similarly to Wilkes and Beale (2001), participants in this study found that family dynamics could be stressful and could have a significant impact on the nurses' emotional wellbeing. Feelings of frustration, anger and distress were evident in the participants’ stories, however there was also an acceptance that all families are unique.
The client might be nearly comatose and not aware of what is going on and in pain and you’re trying to [provide care] but the family are so focused on [the rituals]... I’ve had to withhold my own frustration and allow them to do whatever they are doing [Amelia].

It’s hard when you’ve got relatives swigging on the morphine behind your back so you can’t leave IV medications at the house like you could with other clients [Dee].

The family dynamics were absolutely disgusting...we had to physically break up the fight because the well [relative] was attacking the ill [relative] [Lee].

In the community it’s the family situation, like every family is not rosy... It’s the family dynamics. I had to accept that everybody’s families are very different [Rita].

**Feeling balanced/out of balance**

The participants recognised when their emotional wellbeing was being affected as a result of the emotional experiences. It was clear that acknowledging their human vulnerability was important. Feeling emotionally balanced was important for the participants, however due to the emotional demands they encountered, times of imbalance occurred. When nurses were out of balance, their emotional vulnerability compounded placing additional demands on their internal resources:

I found it really most difficult because I would look at this girl and I’d think this could be my daughter, so on that level I was not able to cope very well [Betty].

At times clinical experiences raised emotions in the presence of clients and family, yet participants validated the events as part of being human:

The relatives and the [client] need to see that you are a human being and not a machine or a robot just coming to do a job. They appreciate a hug and they appreciate a tear now and again especially when they are dying [Dee].
I was just so touched and I could feel my eyes swelling... I regained my composure and when I got out to the car. I rang my manager and cried [Rosemary].

**Organisational/workplace issues**

Scholars have highlighted that workplace environments that are not conducive to promoting the health and healing of nurses could result in nurses feeling inadequately supported (Glass, 2007a; Jackson, 2004; Hutchinson et al., 2006;). Moreover, Vachon (2003) argued that stress in palliative care practice could frequently be derived from the nurse’s personal situation in regard to their work environment as opposed to stress resulting from working with dying patients and their families.

The community nurses in this study shared concerns related to workloads, lack of resources, workplace violence and workplace politics. Reports of heavy workloads were primarily due to lack of human resources resulting in an increased burden of care for many nurses. Nurses on leave were often not replaced. One nurse reported her team were:

> constantly working short. You get busy and you’re flat chat. We have worked understaffed all the time and that is very, very hard to look after yourself and do all those things [Sarah].

Nurses spoke of their working relationships at times making reference to the horizontal violence within their teams. Kay remarked how ‘[t]hat bullying stuff, it does happen. I can see it happening in the weakest link’.

Haley disclosed that the ongoing workplace stress had impacted significantly on her emotional wellbeing leading to burnout. That resulted in Haley taking several months unpaid leave from nursing. Haley shared how the violence in her workplace ‘had been going for a long time and it was quite severe’.

A critical aspect in this study was the perceived availability of adequate resources. Accessing appropriate resources to meet client needs was problematic and a cause of frustration for participants. Amelia searched unsuccessfully to provide a pressure mattress for a terminal client. The emotional impact was evident as Amelia asserted:
Well they’re dying. Would it be so much to have a pressure mattress so that their last few days aren’t uncomfortable!

As a consequence of the challenges, the participants felt ‘frustrated with the inequity in health’. This impacted on their ability to provide quality client care and contributed to increased occupational stress and job dissatisfaction. The seminal work by Vachon (1987) and more recently, Vachon, (2005) and Vachon and Sherwood (2002), highlighted the relationship between nurses feeling able to meet the needs of clients and avoiding burnout. Yet community health nurses are being challenged to provide quality care to clients with less health resources. Two participants strongly articulated their anger and distress with the situation by emphasising the demands encountered in their workplace:

[W]e get told to take on more, we get told to do more but we don’t get [resources]... Client health care services are being eroded, and continue to be eroded, and how are we going to stop that! [Lee].

I just see it being cut, being cut, being cut, and of course the impact on the morale of staff and your own feelings about trust. You’re so frustrated that you can’t provide the service that could be wonderfully beneficial... Everybody here feels upset about that sort of thing happening to our service [Betty].

**Professional recognition**

It is important that community health nurses’ contributions to palliative care practice and the challenges they encounter in practice be acknowledged and validated and made visible. Invisibility perpetuates marginalisation, a status that can maintain the oppressed position that women and nurses hold (Roberts, 2006). Whilst professional validation is important, it is also important that nurses “respect the people you get validation from”. That notwithstanding, recognition of community health nurses contribution to palliative care remains limited, as noted by the following comments.

I think it’s quite well known that what happens is that we might do quite a lot of the care out in the community... I think historically you get the majority of people send letters of thanks to the palliative care team and that we often get bypassed, but that’s people not being clear on the system.
I think that the community nurses never really get recognised for what they do. It’s always the specialist palliative care teams that get recognised and that really pisses me off!

One participant shared stories of ongoing workplace challenges that impacted significantly on her emotional wellbeing. Attempting to implement client support programs she repeatedly encountered obstruction from management resulting in feelings of distress. Covert actions of management had rendered her silent, angry and feeling professionally stifled:

Oh [I’m] as angry as, as angry as!... [Palliative care is] still my passion... I’d be out of here, cause it doesn’t (pause). I’m too stifled, I’ve got too much to offer to be this stifled. I have set myself a time limit. Oh [it’s really upsetting], like I could start crying now.

Most participants’ considered the palliative care role as ‘one of [their] most difficult roles’ within their community nursing practice and as Wallerstedt & Andershed (2007, p.34) asserted, the role ‘demanded great dedication that could comprise both positive and negative elements’. Davy (2007, p.19) attested that community nurses ‘could almost be categorised as social workers with the added benefit of expert nursing skills over and above that’ yet some participants continued to feel that the challenges were inadequately recognised. Shae strongly asserted:

Sometimes [the management] are occupied with numbers and resources and do not really see the value in the quality of the care. To acknowledge the time that it takes to offer that level of care... [The clients] condition changes every day and what I want is the acknowledgement of the level of skills and the depth of skills and the involvement that occurs with palliative care. A valuing in terms of time, how long it takes and even support... Some acknowledgement that, hello, this isn’t easy to do!
Interpersonal communication

Nurses found that there were times that General Practitioners (GPs) were seen to place their own ‘ego and how they look’ above clients’ needs. This was a cause of frustration and concern for the nurses, clearly impacting on the participants’ emotional wellbeing.

Nurses shared how interactions with doctors could be either respectful, or condescending and dismissive. One nurse recalled the emotional impact of having her professional opinion dismissed by the GP. The outcome resulted in the client’s admission to hospital to receive appropriate medication. The participant expressed her frustration in a situation that she felt could have been avoided:

It breaks my heart. Because if it was me that was sick or someone in my family I would be just so angry, and I can get angry (emphasised) but I wouldn’t be able to get on with that doctor ever again and I wouldn’t be able to have a working relationship with them. So, it’s very frustrating.

In addition to GPs, many participants stated, “we do have a communication problem” between the community health and specialist palliative care nursing teams. Of key concern was the failure of specialist palliative care to notify the community health nurses of a client’s death. Participants reported the emotional impact of attending their scheduled home visit and being informed by the family that the client had died.

I mean we’ve turned up at patients’ houses and they had died. And it’s the most horrible feeling... Oh it’s terrible! [Kay].

Quite often I’ve turned up the next day and the client has died overnight and I haven’t found out. I find it really difficult if you’ve been involved with them, you’ve developed this relationship with the family then you turn up in the middle of everything... or you turn up and they all end up in hysterics because they remember you and they feel they can talk to you. You’re not prepared for it. It depends on your relationship with the family as to how difficult is [Amelia].

However referrals were also a source of frustration when provided late in a client’s health trajectory, at times impacting significantly on the nurses. This intensified the emotional
work and emotional energy required by the community health nurses to establish a good working relationship:

[w]e would rather have an early referral so we know then that we can establish some rapport, so we’re not going in when they’ve got the syringe driver in and they’ve got 48 hours and we are going in every day. This has been a big issue [Rosemary].

One participant told how the specialist palliative nurses had “known for months” of the client’s wishes for a home death - the emotions readily surfaced as the nurse explained:

We walked in and this guy was dead. We knew no-one. I didn’t know the client, I didn’t know the family, no-one... Oh it was hideous! I was so angry, I was so (emphasised) angry... There is no excuse.

In addition to the issues with late referrals, the quality of referrals was also an issue for some. These situations created professional vulnerability, hindered quality client care and impacted on the nurses’ emotional wellbeing.

We get referrals and we don’t even know what the cancer is. They are really very vague... we were thinking [the referral] was palliative and it wasn’t and then we think that [the referral’s] not palliative care and it is! [Tishe].

Sometimes it’s really hard... it was so hard to get information on [the client]... We were treating him thinking that he was in the end stages of life and he ended up having radical treatment and returned home. I felt so inadequate then, because I felt I didn’t know enough [Dee].

We need to know so much (emphasised) about these people. We need to know much more than they have a pressure area or they need a sponge! No discussion! No discussion! And that really needs to happen. Then I would probably feel a little bit more adequate when I go to the house [Amelia].
Professional boundaries

The issues related to professional boundaries can be argued as complex and sensitive and demanding. The participants shared many stories that raised awareness of issues associated with nurse/client boundaries. It has been suggested that primarily the nurses’ employ professional boundaries to navigate the challenges of palliative care (McNeely, 1996; Wilkes & Beale, 2001) however those boundaries are subjective and therefore traversed within nurses’ individual circumstances (Lillibridge et al., 2000).

Whilst nurse/client/family relationships are important to nurses, maintaining professional boundaries can be challenging (Wilkes & Beale, 2001). Part of the reason could be that relationships are ‘formed in the clients home setting’ (Luker at al., 2000, p.776). The relationships were important to the participants however, as Shae reported “I have felt that a lot of my boundaries have been blurred”. The main challenge for several participants in this study was to avoid becoming emotionally over-involved and therefore worked toward “maintaining professional distance”.

In exploring this aspect I recall Joy commenting, ‘that’s probably the hardest thing for me’. With client care undertaken in the privacy of the home environment, relationships could be seen as friendships. At times nurses’ compassion and commitment to care resulted in giving of themselves far more than was expected, thus a blurring of the boundary took place. Anna pointed out that:

[s]ometimes you cant stop but go past the client/nurse boundary... The challenge is not to get too involved...where do you cut off?

Blurred boundaries were not isolated to the participants. During the interviews there were occasional references made to what the participants had identified as co-dependent relationships. Of genuine concern to the nurses was the potential risk to their colleagues and clients as a consequence. Their concerns highlighted the strong relationship between professional boundaries, the potential of impaired emotional wellbeing and the need for support for nurses:

You are there as a nurse to facilitate life processes and dying processes and be supportive for the person who is palliative. You are there for the family, friends...
and everybody else. You are not there for your own needs. I have, over many years, worked with people who I would clearly identify cross the boundaries and become co-dependant because of whatever reason in their background or their experiences. It’s their need to be dependent in that situation and I don’t think that is healthy [Louise].

Specialist palliative care services that the participants identified as being under resourced, placed additional demands on the community health nurses. The under-resourcing was not limited to rural sites, moreover it was also problematic in large urban community health centres:

On the ground, in the day-to-day running of things, things get missed, and [specialist palliative care] are short staffed. I think until they have a full compliment of staff there, we are going to continue to have some issues.

One nurse commented, “I know that [the specialist palliative care nurses] are extremely understaffed”. This impacted on the generalist nursing team in that “usually if they can’t manage the workload, then we get some of their referrals”.

Inadequate specialist staffing meant community health nurses faced boundary challenges in that they undertook responsibilities that were considered, in some community health centres, as a specialist role. That resulted in a dialectical tension for the community health nurses between protocol and client care. Limited access to specialist nurses left the nurses no option but to advocate directly for clients’ needs with other service providers. As a result, conflict could arise. On one occasion, the nurse reflected how:

The hospice nurse had ripped shreds of [the community health nurse] because she dare go over her head and contact the doctor to adjust the syringe driver.

However the community health nurses maintained a strong commitment to client advocacy. Another participant expressed her concern when advocating for a client who was in extreme pain. An urgent medication review was required yet no specialist palliative care nurse was available. Failed attempts to access specialist nurses meant direct contact with the general practitioner. Being outside of her usual clinical parameters placed the nurse in a vulnerable position:
[The general practitioner] was basically asking me to do a [client] assessment which I didn't really feel comfortable doing because I'm the generalist nurse. So I was trying to liaise backwards and forth with the GP when he hasn't seen the patient, using previous medication orders as the basis of whatever he is going to prescribe [Amelia].

**Education/professional development**

Research has identified the demand for more frequent palliative care clinical updates and education sessions particularly in relation to meeting clients’ psychosocial needs (Hughes et al., 2006). However participants in this study felt hindered by systems that did not support their professional development, resulting in feelings of disempowerment and distress:

[I]t would be good if we had regular updates or talks with professionals who deal with [anger issues].

Part of the problem was that available resources in the workplaces were limited. In addition, some nurses felt that their voices were simply not heard by management, in regard to their professional development, to the point where one nurse strongly asserted, “it’s sometimes like flogging a dead horse!” Rosemary told how she had requested mentoring programs where staff could feel “validated” yet her suggestions “just get washed over”. As a consequence she felt professionally invalidated and left to reflect whether the health service was in fact “a learning organisation”.

We are limited on the amount of [education] we are able to go to and I do school health and I have to go to that training which is two days out of our entitled three days for the year unless it is mandatory training [Tiche].

We all do circumstantial counselling, you do it with everybody really without even realising you're doing it, but I think in [palliative care] it would be really (pause). How many times is there an awkward silence or you don’t really know what to say [Tiche].
Emotional energy

The findings identified a strong relationship between the emotional demands associated with palliative care practice, the degree of emotional energy required to provide care and the participants’ emotional wellbeing. Participants regarded their palliative care practice as ‘highly emotional’. In fact nurses believed that palliative care was “the most significant emotional burden that we have”. Shae asserted that:

[I]f anyone would think that palliative care isn’t emotional work, then I would think that there are barriers of some sort.

The emotive nature of palliative care appeared to relate to two factors: psychosocial care for individuals and families who were experiencing deep emotions related to their disease progression; and the amount of ‘energy’ nurses’ imparted when caring about their clients. These findings support Dingwall and Allen’s (2001, p.65) use of the term ‘holistic emotional work’.

It was evident that several interconnecting factors could influence the nurse and client outcome related to their emotional work. These involved the degree of emotional demands placed upon nurses in regard to client and work-related issues, internal and external resource capacity, the ability to identify problems and the power to implement change. The participants shared meaningful tales that highlighted the value of client interactions and the relationships they formed. As nurses recalled their experiences, laughter and tears often merged, creating added meaning, however the potential stress associated with emotional work must not be underestimated (Skillbeck & Payne, 2003). One nurse described feeling as if:

[y]ou’ve ‘taken some of the load off [the clients] shoulders and put it on yours. You walk out feeling like a ‘rung out rag’!

Emotional work is therefore embodied in caring and the use of self is intrinsic to nursing care (Weir & Waddington, 2008). The nurses regarded palliative care practice as emotionally draining, demanding or exhausting. For example:

I find it really exhausting actually, I find it very satisfying (long pause) but also very draining [Sarah].
Palliative care takes all of your energy. You don’t have any energy for your family, you don’t have energy for your life [Tiche].

Feeling emotionally exhausted was acknowledged as having implications on client care. Tiche remarked:

So I identify that if I overdo it with palliative care, and it’s not fair on [the clients] either because when you are sucked out, like... if you don't have any juice left, you are not giving those clients as much as they deserve, that's how I feel.

There was an acceptance by many community health nurses that they did not have the power to action change in the workplace. Lack of professional development opportunities resulted in increased practice demands. For example one nurse shared:

We are not doing anything wrong its just if [palliative care team] are telling the clients family one thing and we are going in and doing something different, then you feel like a bit of a goose.

We will be doing things that came up in that course two years ago and we are relaying that to our clients and then [we find out] no, no we are not doing that anymore [Dee].

The efforts to change the status quo required emotional energy. Nurses expressed disappointment at not being given the opportunities:

Keeping up to date with best practice. Things change and not knowing that there is a different way now. We rarely get an up to date with palliative care as part of our education.

[There are some things that you have to let go. My emotional energy is not (long pause). I’m not going to get anywhere here.]
Emotional support

Staff shortages placed an emotional burden on the nurses both physically and emotionally. As a result, nurses identified a need for emotional support. Many nurses felt supported by their colleagues and Nurse Managers, however not all participants had similar experiences. One participant told how:

[y]ou couldn’t go in and say “Oh, I’ve just had a terrible time at [a client place]”. I think it’s her personality (reflective pause), and that does really impact!. [You] just don’t go there.

Sarah revealed the problems she had with her Nurse Manager. Her story reflected sadness between ‘what is’ and ‘what could be’:

I never go and talk to my boss… its kind of a double-edged sword. She’s offering her support but in practice, she often doesn’t support you… It’s a big control thing.

Power/control and politics in the workplace were also of concern. If the participants work environments were not conducive to promoting the health and healing then access to emotional support was limited. Nurses reported that “the politics, there is just too much of it”. Rosemary strongly asserted:

It’s the politics that gets you down. It’s the politics, it’s the power struggle, it’s not actually the patients, it’s everyone’s little power struggle... I find that difficult.

There were occasions during the interviews that participants expressed concern for their colleagues and their need for additional support. Participants identified the relationship between support, emotional wellbeing and quality client care.

Sometimes I concern myself with other staff. Concerned about staff that are dealing with palliative care when I know that they maybe haven’t got the background or haven’t got the support that would make it easier for them... I am very aware that you have to look out for one another to give the best care. Personally and that can be quite challenging [Taylor].
Feeling empowered/disempowered
Data analysis revealed a permeation of opportunities for, and experiences of, feeling empowered and/or disempowerment. Participants’ perceptions of power and empowerment are considered important to nursing practice and to nurses’ health and wellbeing (Glass, 1998; Rose, 2002; Rose & Glass, 2006).

Whilst palliative care was considered “complex” and “emotionally demanding”, feeling empowered was often associated with positive emotional wellbeing. Nurses shared their stories in relation to client advocacy, meeting clients’ needs, accessing clinical and emotional support and self-care.

Experiences associated with feeling disempowered became apparent when nurses believed quality client care was being compromised by resource restraints, or where workplace issues such as effective communication and education, impacted on the quality of their client care. Feeling disempowered could result in impaired emotional wellbeing:

[w]e have worked understaffed all the time and it is very, very hard to look after yourself and do all those things [Haley].

The emancipatory framework that informed this study aimed to promote empowerment, transformation and opportunities for social change. Supporting the women to speak out about their experiences and feel acknowledged and validated for the meaningful contributions, was congruent with feminist epistemological processes.

During the interviews it became clearly evident that some participants had felt disempowered as a result of work related stress, yet this proved to be a complex space. One participant perceived her stressful situation as:

All mine. The hospital hasn’t inflicted this [stress] on me... We are going to have nurses go out on stress leave. Yeah, Sick! I think the reason I said I need to own it, it is my responsibility because its part of my personality and I know that it’s a fault and I need to put it out there.

Through the processes of support, reflection and self-awareness, a raised consciousness led to an empowered state, creating an opportunity for change:
I agree with you that because of my [palliative care] work that I am experiencing this stress. Yeah, that’s great, bring it on! (laughing). I think that we need to support one another a bit more even though I have a great rapport with my colleagues here.

**Rewarding**

Within this theme the participants stories will reveal the multiple aspects to their role that were considered rewarding. These will include the interwoven elements of job satisfaction; interpersonal communication; emotional energy; emotional support; feeling balanced/out of balance; feeling empowered/disempowered; and self-care & healing. I will begin by discussing job satisfaction.

**Job satisfaction**

All participants in this study considered palliative care as a rewarding role and a source of job satisfaction. Scholars have argued that job satisfaction is an important predictor of intent to stay in nursing and moreover has been related to quality client care (Caers et al., 2008). Wallerstedt and Andershed (2007) found that palliative care nursing was stimulating and satisfying and that nurses experienced feelings of happiness and generosity. The rewards for participants in this study could be identified as nurses spoke about client advocacy, the trust they received from clients and feeling they had made a difference to client outcomes. Of most significance was that their palliative care role was perceived as being a “privilege”. Nurses clarified the term “privilege” by adding:

You are very privileged to be there looking after [clients] during that part of their life [Taylor].

Well privilege from the point of view of how the patients invite you into their lives. Depending on how much actual input you have with that family is really dependent on how much they do invite you [in] [Lee].

The privilege for Louise was twofold. Firstly “it is a privilege because you are able to do [palliative care]” and secondly the privilege related to the trust between nurse and client as, “palliative care patients off-load in their dying hours to you”.
Trust between nurse/clients/family was important and valued. Sarah reflected how clients:

- [s]hare amazing things with you. It’s so special to be there... It’s like wow!
- Would you actually share that with me!

Louise reflected on the situations she faced when put in these challenging positions, yet simultaneously acknowledged the significant role she had in supporting her clients' healing process:

- Just the deep dark secrets that people have, everyone has them. I just think it’s amazing and no it doesn’t go anywhere, it doesn’t worry me, I guess I see it as a privilege to have someone feel safe enough to tell you their deepest secrets.

Clearly one of the most significant sources of job satisfaction was when nurses believed that could make a difference to clients and families in their care:

- I’m quite happy if I think I’m helping somebody and if you think you’ve made a difference, that’s even better [Joy].

You hope as a nurse that you do play some role to make their lives better. Certainly with palliative clients to make things a little bit easier. There are definitely lots of positives [Rita].

Advocating for clients and promoting quality client care was a source of job satisfaction for nurses and therefore impacted positively on their emotional wellbeing:

- You know you have done the best you can and that your input made a difference [Lee].

- Even if I’ve had a bad day I still feel like I have done something good [Dee].

**Interpersonal communication**

Data analysis revealed that rewards was derived from varied aspects to their professional practice however, of most significance, were the relationships they developed with clients, families and colleagues within the multidisciplinary team, many of which were considered a
privilege. Implicit within those relationships was interpersonal communication. When the interpersonal communication was considered effective and of quality, the relationships were found to be rewarding and better client outcomes could be achieved (Andrew & Whyte, 2004; Law, 1997). For example nurses remarked:

The [community health nurses] that I work with are excellent and I can just ring them up and say [blah] and they are so good... we know each other’s strengths and weaknesses and we work well together [Anna].

So there might be a different outcome but at least I can show that I have tried to do what I thought was the best action [for the client]... I’m just working as a [part of a] team and sending information there and [doctors] are writing back thanking me for the input [Sarah].

Developing relationships by getting to know the client and family requiring palliative care has been identified as “the essential antecedent for the provision of good quality care” (Luker et al., 2000, p. 777). The meaningful relationships revealed in this study as being a privilege, on occasions reached a deeper level of connection. Lee termed this as a ‘special privilege’. The special privilege was identified as ‘a connection [with clients] that you don’t make often’. When the relationships were rewarding, they experienced a positive impact upon their emotional wellbeing. Haley reflected the rewards she attained during her care with one family:

For [my emotional] wellbeing, that family gave me so much you know. They gave back to me so much, as much as what I had shared with them [Haley].

Collaborative relationships with other health professionals were also important and had the capacity to also impact positively on the wellbeing of the nurses. Some considered them as “fantastic”. Nurses revealed that being supported by their colleagues was important, and in particular, feeling heard.

We have a really close team here, so we can discuss things... I’ve always got someone around. It’s a really supportive environment. [Amelia].
The Medical Director is fantastic. I can’t say enough about [name]. Absolutely fabulous!... She does not make anybody feel like they’re being missed out in the loop, so you know she will hear you. [Haley].

**Professional recognition**

The community health nurse role associated with palliative care is complex and multiplicitous, (Rose & Glass, 2006). Penz (2008, p.298) argued that professional recognition of community health nurses and their role as palliative care providers, must take into consideration the “complex interplay of the additional roles that they fulfil”. Scholars have highlighted that a strong relationship exists between the empowered nurses and how they perform their nursing responsibilities. Being recognised and valued for the contribution to palliative care could promote self-confidence whilst promoting personal empowerment. Kuokkanen and Leino-Kilpi (2001, p.273) assert that, “an empowered nurse possesses those qualities which make possible high self-esteem and successful professional performance and progress”. One of the outstanding values that the participants in this study embraced, was their focus on holistic client care, highlighting similar findings to McDonnell et al. (2005). Reference to holistic care was explicit and implicit in the interviews. However, according to Parkinson, (2006), the capacity for nurses to achieve holism remains in question. One of the reasons holism could be ‘less attainable’ could relate to the many changes experienced by community nurses over the previous decade (Luker et al., 2000, p.775). One participant identified changes to palliative care provision, arguing that:

>palliative care is becoming so specialised that they’re just missing the essence of it being holistic care.

That notwithstanding, the participants in this study valued palliative care, supporting the findings of other scholars (Goodman et al.,1998) embracing the holistic philosophy:

Holistic. Absolutely holistic! A palliative care client is not just a labyrinth of cells doing the wrong thing, it’s the effect that it has on them as a whole person, on their whole family, the community they live in, all of their friendships that sort of stuff. If you think you can only deal with one person in palliative care, the client, then you’ve got buckley’s. You have to deal with all of those significant people whoever that might be [Shae].
Emotional energy

Scholars have reported that providing quality palliative care to clients living at home is important to community health nurses (Kennedy, 2005; Luker et al., 2000) yet such care is not free of challenges in the physical and emotional domains (Luker et al., 2000). Whilst the nurses’ roles were multifaceted and care client specific, it was the client’s physical needs that as Luker et al. (2000) argued, would generally direct the nursing role. The participants affirmed, ‘the physical issues are often what we go for, the emotional issues are what we leave with’. Care was also directed by a common understanding that:

[t]he clinical stuff is important because you have to do that well but more important [are] the emotional issues, far more important.

The emotional energy associated the participants’ practice was founded on the basis that:

I always like to think that if this were me and I was dying how would I like a nurse to come into my home to treat me. That directs the way I care for palliative clients [Anna].

The rewards associated with care were measured by the quality of care and not against achieving the desired outcome. Participants were aware that:

We are going to be putting a lot of energy into, we are going to be tested in our approach not just to the client but to the relatives, so its not just the client we are going to be looking at you know you are going to be looking at the relatives, the friends.

Nurses shared stories that reflected the difficulties and sadness yet simultaneously acknowledged their own contributions. Participants’ comments reflected the satisfaction and the association it had with their wellbeing. Dee told how “emotionally it was very hard” yet strongly asserted, “If we had to be there for two hours then so be it”. Amelia expressed a view of many when she declared, “at the end of the day, I just have to go home and sleep at night”. 


Feeling balanced/out of balance
In Aim One the participants had highlighted that emotional wellbeing was significantly related to the concepts of feeling balanced or out of balance. Nurses had to balance many aspects of their practice, such as time and priorities.

Feeling balanced or out of balance had the potential to impact upon nurses' professional practice. Awareness of their emotional status provided opportunities for the participants to re-balance their emotional energy and enhance their wellbeing. Rita told how her boundaries were blurred when feeling out of balance, yet support from her colleagues provided new insights:

[Friends] tell me when I'm too involved, and tell me to step back and someone else can deal with that. Sometimes I think that maybe [other community health nurses] wouldn't do it the same as me, but I know there is no 'right' or 'wrong' way.

When participants felt emotionally balanced they recognised the positive impact on client care:

I can take myself out of the picture and take the emotion out of the picture so I can look at what is really happening so that I can help [the clients]. I can help [clients] manage their pain, their physical stuff as well, and manage the coping mechanisms in the family [Shae].

Just knowing that you do your best and knowing sometimes that no matter what you do you can't change an outcome always. Its not about walking away from it its about recognizing it [Lee].

Feeling empowered/disempowered
McGarry (2007, p. 134) believed empowerment to be a positive step that will strengthen community action and can be “achieved by acknowledging family competence and preferences”. Participants strongly believed that empowering clients and family was not only a core aspect of their role, but moreover, it was critical to client outcomes. When nurses were able to empower their clients, they in turn shared feelings of empowerment:
You go in and see a chaotic family and you know that you are pushing shit up hill but all you can do is to stay consistent... Consistency is one of the most vital tools a nurse has. That’s where you can empower your client to believe that they have the skills. You make them the experts [Lee].

Reflecting on palliative care experiences raised mixed emotions for the participants such as joy, sadness, anger and frustration. Some of the nurses were distressed at various times as memories of the demands and rewards emerged, however this study provided an opportunity to share their experiences, validate their roles, to tell their stories, and most importantly, feel heard. Examining the congruence between methodological congruence and research process is critical. Participants’ initial responses to the invitation to participate in this study reflected that acknowledgement of their contribution to palliative care practice was important. Comments included, “I would be happy to participate in your research”, and “I would relish the opportunity to be a subject of your studies”. During and post interview, I believed that nurses felt their contributions were valued and the process of feeling heard was, in itself, empowering for some participants. One participant later confirmed, “It’s good to talk about all that stuff. It was good”.

**Comfortability**

This final theme aims to demonstrate the participants’ experiences associated with comfortability. These will reflect feeling comfortable and uncomfortable. The interwoven elements included in these discussions are, job satisfaction; feeling empowered/disempowered; professional recognition; education/professional development; self-concept; professional boundaries; perception of emotional wellbeing; feeling balanced/out of balance; emotional energy; and self-care & healing.

**Job satisfaction**

The participants strongly articulated their satisfaction related to palliative care. Amelia said “I love my job and I can't imagine what else I would be doing”. Taylor concurred stating, “I love it, I really do”. Whilst all nurses revealed many rewarding aspects to their role, nurses also held juxtaposed positions between the demands and the rewards. This in-between space required nurses to reach a place of comfortability in their practice. For example, one nurse expressed the dialectical tension between satisfaction and frustration,
when caring for her clients. During one of her stories, the reality of feeling uncomfortable with the client’s dying process was reflected, yet simultaneously the participant sat comfortably within her decision to respect the client’s wishes, support his decision and move forward to support him and his family through the terminal stage of his life:

It is frustrating because I have my own personal ideas about how I would face my own death and I have seen lots of people die so I have witnessed how a lot of people approach their death and some people do it really easily and gracefully and some people do it with a struggle and are miserable... I know when I have to back off from people and to leave them to do it their own way, well that’s all of the time, but you can’t really ‘get in’ when they might not even want to talk about the fact that they are dying up until the moment of death... They are really frustrating to be with but still you do the best you can to give them what they want.

Comfortability was important, particularly as nurses spoke of the impact their emotional work could have on their emotional wellbeing. Feeling comfortable within their practice required a strong self-awareness, the ability to be reflective in their practice and the capacity to respond to challenging situations with emotional intelligence. That notwithstanding, providing the best care possible was at the heart of the participants palliative care practice. Betty affirmed:

I think when you are handling palliative care clients you need to feel comfortable that you are doing everything that you can possibly do to help that patient get through to the inevitable the death. I find it a really the most satisfying part of our clinical work.

**Feeling empowered/disempowered**

Client advocacy was identified as an aspect of practice that could lead to empowering outcomes, yet nurses’ efforts were at times challenged, creating a tension between feeling empowered and disempowered. One participant revealed how she overcame a contested issue, related to pain management, by reframing her language to ensure the client’s needs could be met. That required the nurse to reach a point of comfortability, affirming her strong commitment to client advocacy with her decision:
[I have] done a lot of public relations work [with general practitioners] and taken a fair bit of slack from confronting pain management... Lots of times I don’t use the word palliative... I said I’m a cancer nurse really. I’m talking about symptom management, that’s my main issue here. [The doctor might say] “Oh, yeah, okay”. [I decided] just don’t talk palliative [Haley].

There was also evidence to suggest that the participants needed to reach a point where they felt comfortable with taking a particular stance in regard to communication difficulties. Rosemary had spoken of the disempowering relationships she had with a senior colleague. Whilst the problems had impacted negatively on her emotional wellbeing, her reflective skills and access to emotional support had enabled her to reach a point of comfortability with her situation. Whilst the issue was not resolved, Rosemary’s insight made possible a transformative space. A state of empowerment emerged that in turn, enhanced her emotional wellbeing:

I can take comfort in knowing that it’s not just me that feels that (laughing). Like I don’t think I’m the victim... I know I’ve learnt to look at other people’s interactions with other people... and then you’ve got to take comfort in thinking, well its not just me, its something else, and I’m not going to take responsibility [Rosemary].

**Professional recognition**

My conversations with some participants led me to believe that the lack of professional recognition was partly an impetus for their participation in this study. Scholars have identified that whilst nurses seek out opportunities in the workplace that could lead to new challenges and professional recognition, they were not being realised due to a “person/occupation misfit”, often associated with lack of time and resources (Takase et al., 2005, p.32). Not only did nurses believe that “a lot of people don’t know that the community nurses are out there” but some also held the view that their role as palliative care providers was not adequately understood or recognised by some specialist Palliative Care Nurses, general practitioners and at times members of the community. There was a strong belief that professional recognition was generally given to the specialist palliative care team, resulting in the generalist contributions being relatively unacknowledged. The
lack of acknowledgement created feelings that generalist palliative care work was less valued and thus their palliative care practice remained largely invisible.

Whilst the invisibility could be contested, what could not be contested were the beliefs of some community health nurses that, “there are no clear guidelines” to direct their palliative care role. This raised the concern by another participant who sought clarity over “when is palliative care palliative care?” The lack of clarification was a concern, creating a degree of uncomfortability for participants who had limited access to palliative care updates and professional development opportunities:

We had a palliative care session last year and I’m surprised that we weren’t given any guidelines. You are not allowed to access a Port-O-Cath without training, so why is palliative care any less important [Tiche].

Whilst the concern over practice guidelines was problematic for some, other participants were comfortable with their positions. In particular, nurses demonstrated a strong focus on, and a commitment to, client advocacy and the quality of client care however these challenges were one of the less visible aspects of their palliative care practice. Whilst these issues have been discussed previously in terms of the associated demands and rewards, nurses state of comfortability or moreover, uncomfortability, were pertinent to their experience of emotional wellbeing:

I have to offer what [the clients] perceive they need... You have to respect their issues even if you don’t like them. The hardest thing in the world is to let them die without help.

My role is clear. I’m like [specialist palliative care’s] Achilles heel. They hate having me there... I’m the [client and nurse] advocate.

**Education/Professional development**

One prominent source of frustration for some community health nurses related to their perceived lack of ability to confidently address the psychosocial needs of clients and families in their care. Many services were fiscally restrained leading to inadequate resources. This was not to suggest that all of the participants felt uncomfortable. In contrast, some nurses were highly educated in psychosocial care and others were
comfortable with the support they received from specialist palliative care services. Yet for all participants, opportunities to advance their skills in the workplace were less than optimal.

As generalist community health nurses, it was not uncommon for the participants to have other areas of expertise that required yearly education updates. A dialectical tension then existed between the need for education to advance knowledge and skills, limited sponsored education opportunities and what to attend if the opportunity arose. With competing practice demands, some participants confirmed:

> We have been told that we are only entitled to three days per year training unless it is mandatory.

Limited access to counsellors and social workers within the public health sector placed additional emotional burden on participants. As a consequence, several nurses expressed a degree of uncomfortability when confronted by sensitive end of life discussions, yet the findings confirm that the emotional aspects of care were considered the most demanding. Dee spoke out, emphasising her frustration, whilst simultaneously revealing the emotional impact on her wellbeing:

> That is the most frustrating thing for me because although you can sit and listen, I don’t feel I am a psychologist... I just don’t feel like I am confident in that area and there is such a lack of counsellors. So that is really hard for me.

Compounding the pressure faced by some participants, reports of feeling “inadequate” emerged. One nurse told how she felt “inadequate sometimes to answer [clients’] random questions” whilst another participant shared how “sometimes I don’t know what to say and sometimes [I’m] crying as much as they are”. Feelings such as these impacted on nurse’s emotional wellbeing and placed them in positions that exposed them to increased emotional vulnerability.

**Self-concept**

The self-concept of nurses and its relationship to professional practice has been subject to recent inquiry (Arthur, & Randle, 2007; Cowin et al., 2006;). Arthur and Randle (2007, p.60) argued that understanding nurses’ self-concept is vital ‘as it affects patient care’ however
there remains a gap in the literature regarding generalist community health nurses self-concept and palliative care practice.

It was evident in this study that whilst most participants clearly accepted palliative care provision as ‘part of our role we play as nurses’. Many nurses derived great satisfaction and considered palliative care as one of their clinical strengths. However many nurses disclosed deeper feelings that had the potential to impact on client care and their emotional wellbeing:

The hardest think that I find is that because [clients] have that complete trust in you, you feel almost guilty for going home...I would almost love to give them my personal mobile and say ring me at home if you’ve got any problems [Tishe].

The data exposed a dialectical tension between providing quality palliative care and feelings of inadequacy for two nurses. That had the capacity to impact upon the nurses’ self-concept as palliative care providers. This was evident as nurses revealed that:

We don’t have a choice. No, if we get a palliative care patient we take them on but it’s this inadequacy, am I doing it right. It’s more that I hope I’m getting it right’.

I wouldn’t do it if I didn’t have to. If it wasn’t part of my job I wouldn’t voluntarily do it because it is draining and because each day you don’t know what you are going to find when you get there... It’s very unpredictable and you can’t tell, things might even change while you are there, its very touch and go I find.

**Professional boundaries**

Professional boundaries were essential in meeting the demands related to palliative care practice. However the boundaries were subjective and nurses’ capacity to determine the boundaries was associated with their level of comfortability within the situation they encountered. It was apparent that a dialectical tension existed for some participants as a result of a lack of clarity between their generalist palliative care role and the specialist palliative care role:
We really need to have a better understanding of what our boundaries are, or if there are boundaries.

One of the participants expressed her confusion following her move from an acute care sector to community health:

I didn’t understand what my role as a palliative care generalist nurse... I even asked questions about where do I fit in to palliative care, when does the palliative care specialist nurse role stop and the generalist community nurse role start and there were no clear guidelines around that. Everybody had a different understanding and said [I] would get used to it.

Yet several years later and her role still remained ambiguous situating her in a continued place of uncomfortability. This impacted on her emotional wellbeing engendering a feeling of ‘looking disorganised’ and was a cause of unnecessary confusion for clients:

I still have issues around knowing exactly what my role is and when you go in as a generalist community nurse and trying to explain to the family how you are different to the palliative care [specialist] team, they’re confused.

To counteract the emotional demands related to palliation, nurses identified the need to implement professional boundaries as a self-care strategy. Nurses sought to feel comfortable to minimise their exposure to emotional harm. Shae and Kay both confirmed that, “some of it is my own boundaries to protect myself”. Kay identified her emotional vulnerability when undertaking the emotional work associated with palliative care and proactively engaged emotional boundaries:

I have a philosophy with my work that I’m not going to get attached to people otherwise I will have too many people and it will all get too emotionally draining. So I just cut off.

The other aspect related to professional boundaries was associated with the division of generalist and specialist palliative care community practice. Law (1997) reported from her study that the generalist and specialist roles overlapped although the generalist nurses believed they provided more psychosocial care such as counselling. The main concern for
participants in this study was to ensure that their clients’ needs were appropriately met. To do so, participants required a comfortability to engage in their desired level of care. Whilst the majority of nurses worked comfortably within the multidisciplinary team, when specialist and generalist services were both short-staffed, additional burden was placed on the community health nurses to respond to the clients’ assessed needs. As Amelia asserted:

*Our role is whatever is required at the time basically and to do whatever it takes to make the person comfortable (long pause).*

The participants in this study identified the links between their professional practice and their emotional wellbeing. Shae revealed a juxtaposed position between providing the high level of client care she perceived as necessary to meet clients’ needs, and alternatively, accepting the impact to her emotional wellbeing arising from the additional demands:

*Because you choose to deliver palliative care in that manner, that you offer that level of service, the impact is always on you. You make that decision [and] you wear the fact that you are never off duty on time. You invest your own time into the delivery of palliative care and into the maintaining of the quality of that care.*

**Perceptions of emotional wellbeing**

Data analysis found a strong relationship between professional practice, self-awareness, perception of emotional wellbeing and transformative opportunities. A raised awareness of the emotional impact, associated with palliative care nursing practice, was the first step toward the nurses enhancing their emotional wellbeing. Self-awareness preceded the stage of perception. Perceiving emotional status was critical to the enhancement of wellbeing. Perception also determined the presence/degree of emotional vulnerability. The perceived presence/degree of emotional vulnerability then created opportunities for transformation and change. Transformation and change could enhance emotional wellbeing. Enhanced emotional wellbeing could increase job satisfaction.

The nurses’ perception of their emotional wellbeing assisted in determining how palliative care was provided, and moreover, what steps they should take to care for themselves. To highlight the importance of the nurses’ perception of emotional wellbeing I draw on my interview with Joy.
Joy shared a story about a young woman she had cared for, reflecting on their relationship and the related practice issues. Joy had earlier confirmed that, “Yeah, I tend to get [emotionally] involved”. As was the case for all participants, caring for younger clients was considered extremely challenging. Joy recalled:

Putting yourself in that position or thinking, well, this could be me or [my loved one].

Joy verified how it “was really upsetting”. She was aware of the emotional impact it had on her during the care provision process, yet throughout the retelling of the story, Joy remained tearful revealing her emotional vulnerability. Her perception of the emotional impact to her wellbeing was reflected as she recalled how it “affected me so much... it was one of the hardest things I’ve done” confirming her vulnerable space. Her insight created an opportunity for a transformative change to enhance her wellbeing. This was acknowledged when she stated:

I actually sat up and typed [my feelings] all out. It was about two foolscap pages about just how I felt at the time... It was very therapeutic.

For another participant, feelings of inadequacy in her communication resulted in her confirmation that, “the emotional feelings I have are more around inadequacy”. In her reflections Kay was focused on “giving this person the best opportunity [to emotionally open up]” yet a dialectical tension existed as she highlighted the issue of “not giving it to them because I don’t know what to say”.

It was clear that the Kay was very aware of the potential implications to clients’ process as well as the actual impact it had on her own emotional wellbeing that resulted in feelings of “inadequacy”:

Emotionally I don’t feel I have the tools to be able to understand where everyone’s coming from and deal with it.
Feelings of disempowerment and vulnerability developed from professional inadequacy. The interview process created an opportunity for reflection and change that led to an empowered state and a transformative shift:

So that would help me with that process to feel strong and happier about it.

Yes, I will look at myself. It’s just committing to it.

**Feeling balanced/out of balance**

The interconnectedness between balance, comfortability and nurses’ emotional wellbeing was emphasised by Sarah who identified the importance of taking time out between clients to restore emotional balance:

Sometimes I just can’t go to another person’s house for a while no matter how busy I am. I just can’t [Sarah].

Nurses struggled with a dialectical tension that existed between supporting the client end of life choices and maximising the client potential for a good death. Sarah’s tension was revealed within her emotions:

Oh it was really hard. Some days it was this real thing of having a dread. When I pulled up in the car I didn't want to go in there because I knew, it was this tearing thing inside of me and yet there was this pull as well to go in because I really felt they needed me to be there.

Under difficult circumstances, Sarah described how she managed the emotional challenges to ensure quality client care, whilst simultaneously caring for her own wellbeing:

I couldn't do anything and I just had to be there for him, so what I ended up doing was that I would go there and I would dress his wounds which were kind of secondary to what he really needed, and I would just sit in the dark with him and massage his feet with warm water and oil of lavender in it and he used to love that... When I left the house I always did (long pause). I suppose when I go in there, before I go in, I feed myself positive affirmations that everything will be okay and things will work out for these people.
Emotional energy

Nurses’ capacity to ask for support could determine their degree of comfortabillity with palliative care practice. Palliative care practice could impact significantly on the nurses’ emotional wellbeing:

I have said before to [my colleagues] I a need break this time, can someone be the main carer... because when you have a run of people, I feel emotionally not able to cope with it anymore... Palliative care takes all of your energy. You don’t have any energy for your family, you don’t have any energy for your life. You’re flat, get rundown and sick, catch colds and viruses that are going around just because you are emotionally, mentally an physically drained, that’s how I feel... If you don’t have any juice left, you are not giving those clients as much as they deserve. That’s how I feel [Tiche].

The participants also applied emotionally intelligent strategies to manage the emotional issues and support their professional position. According to Reeves (2005, p.173) emotional intelligence involves ‘the ability to recognize and identify one’s own feelings’. Emotional intelligence enables nurses to work with emotions whilst not being controlled by them. Betty explained how she managed one difficult situation:

Every time I went up to her door I had visions of “if that was my child”... ‘I responded to it personally but I tried to manage it professionally.

Haley was caring for a young mother who sought her assistance to finalise personal matters. Haley recalled how she needed to manage her emotions when the client asked, “What am I going to do about my kids and what sort of letters do I write?”. Responding with emotional intelligence assisted Haley to remain focused on her client’s emotional needs, whilst in the home environment, yet simultaneously managed her emotions in pursuit of professional practice. Haley told how the situation was:

emotionally very draining for me as a practitioner as well. She just puts herself there and you have to make it very real at the time.
Self-care & healing

Empowerment was also revealed as nurses discussed challenging cases and spoke of their ability to reach out to seek clinical support when necessary. Seeking clinical support was an empowering process that promoted self-care:

I usually say [to my colleagues] that last time I was the primary care giver, this time, you do this one. You change the situation before it comes an actual problem, [that is] if you can identify that, hey, ‘I need to look after myself here’.

The acceptance of being ‘human’ and nurses’ capacity to provide the best possible care was highlighted within many stories. Of most significance was the importance placed on reflective practice as an empowering tool:

I don’t beat myself around the head because you do what you can at the time. You can do with, what you have to work with, and learn from it.

If I am particularly close to a family I will go to the funeral [Rosemary]

Oh I don’t know. After she died I was really upset. I wanted to go to the funeral in one way and then in another way I thought I don’t really want to adopt this family. It has happened to me at different times [Joy].

You have to let go and you do have to have closure for yourself otherwise you will spend your whole life devastated... I don’t always go [to funerals], but the ones I am really connected to, then I will move heaven and earth to go because I need to say goodbye speeches, to grieve, to cry, to say goodbye and it’s nice to have closure with the family [Shae].

Arthur and Randle (2007, p.63) stated that ‘there is a need to explore the issue of professional self-concept at different levels from individual to organisational’. They additionally warn that other factors must be taken into account when exploring self-concept such as individual, social and cultural aspects. A positive self-concept was reflected as nurses spoke with self-confidence about their ability to provide palliative care:
I think I am very good at [palliative care] because... I have the ability of entry and sometimes can just step into the space just long enough to move some of the rocks out of [the clients] path [Haley].

I’ve got such high standards... I am respectful and on the ball. A patient advocate [Rosemary].

In contrast, lack of confidence in the skills to care for palliative clients and their family suggested a lower level of self-concept:

I don’t think I’m qualified in any degree. These palliative [nurses] do courses and I imagine they’re told what to do.

Nurses also identified themselves as being ‘very compassionate’ and focused on care that was ‘empathetic not sympathetic’. Tishe affirmed that:

[o]ne of my strengths as a palliative care provider is to give [the clients and family] strength. I go home wrecked, but they seem to be coping a lot better when I leave.

It’s a closure but it’s very (reflective pause). You go to the funeral and you listen to all the things that have been said about this person who has died and you internalise all that and I found that that was just an added emotion for me to carry... I just don’t go to funerals any more [Betty].

**Conclusion**

This aim revealed that a pervasive interconnectedness existed between emotional work, emotional wellbeing and palliative care practice. Within the interconnectedness were many interwoven elements. The interwoven elements moved fluidly within the connectedness yet emerging from within three central themes, namely: demanding, rewarding and comfortability.

The participant’s subjective experiences revealed that their palliative care practice was a demanding role and was considered emotional work. It was evident that nurses
encountered challenges that were interpersonal and intrapersonal. Some of the key demands were associated with communication, organisational and workplace issues, lack of education and their capacity to meet the psychosocial needs of clients. Nurses drew attention to their levels of frustration associated with lack of resources, to provide quality care. Professional recognition, feeling unacknowledged and at times invalidated for their skills and knowledge resulted in impaired wellbeing. However, whilst these could result in nurses feeling disempowered, quality client outcomes were the primary goal. Palliative care practice had the capacity to deplete the participants’ energy resources. Emotional support was necessary to restore energy, create balance and enhance wellbeing, yet nurses’ identified need for clinical supervision was not readily addressed, creating a significant gap.

Notwithstanding the demands associated with palliative care provision, all participants in this study identified aspects to their practice that were rewarding. They regarded their work as a privilege and valued their relationships with clients, family and colleagues, all in the hope of making a difference to those lives journeying through the palliative stage of life. Effective communication, professional recognition, a focus on holistic care and feeling empowered within their practice were all positive aspects of their practice. To restore energy levels nurses reached out for emotional support. When nurses felt emotionally balanced and had a feeling of emotional wellbeing, their ability to provide high quality care was improved. Self-care was thus a critical aspect to enhancing their wellbeing. The research process was also rewarding, as nurses shared their experiences of practice, creating visibility and of most importance, speaking out and feeling heard.

Through analysis of the data emerged the third theme related to comfortability. This theme focused on how comfortable or uncomfortable the participants felt with various aspects of their palliative care role. The interwoven elements demonstrated that there were no polar opposites, in that palliative care practice was not only about the demands and rewards. Moreover, comfortability was the best indicator of the nurses’ ability to meet the standard of care that they set themselves. Nurses sought to make a difference to peoples’ end of life process, and when they felt empowered, educated, supported and emotionally balanced, nurses felt an increased comfortability in their capacity to care. However, there was a dialectical tension between nurses’ desire to provide quality care and their capacity to do so given limited resources and time restraints. These could result at times in a blurring of professional boundaries.
Professional boundaries were therefore created through a subjective lens and developed by their level of comfortability. Alternatively, if nurses were challenged by feelings of inadequacy in their professional ability, feelings of uncomfortability were created. The findings suggest that intrinsic to community health nurses’ emotional wellbeing, quality client care and optimal client outcomes are the interconnecting themes of demanding, rewarding and comfortability. I will now introduce the manuscript that was developed based on the findings of this research aim.

**The manuscript**

The paper entitled: ‘An Australian investigation of emotional work, emotional wellbeing and professional practice: An emancipatory inquiry’ was submitted for consideration with the internationally peer reviewed Journal of Clinical Nursing. It was accepted with minor revisions on 14th November, 2008.

This paper was developed from the findings related specifically to research Aim Two as discussed above. Therefore the reader can expect to find some repetition in relationship to content. Due to the word limitations of the publication, this paper contains a more succinct analysis. Before reading the manuscript, I have included the relevant details related to submission and authorship. In order to differentiate this manuscript from the main text it is presented in “Times” font.

**Manuscript details**

Journal article removed due to copyright restrictions. (pp. 205-230)

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Research Aim Three: Strategies that promoted emotional wellbeing

Preamble

The discussions in this sub-section represent the findings that have emerged through the analysis of the third aim. This consists of an outline of the specific identified themes; the publication on the themes and a summary of this aim.

The publication that forms the basis of this aim is entitled: Enhancing emotional wellbeing through self-care: The experiences of community health nurses in Australia. The publication details are: Rose, J. & Glass, N. (2008). Enhancing emotional well-being through self-care: The experiences of community health nurses in Australia. Holistic Nursing Practice 22(6), 335-346.

Findings

The third aim set out specifically to explore and investigate the strategies that promoted the community health nurses’ emotional wellbeing. With an emphasis placed on providing holistic palliative care to clients, I was interested to know the value placed on holistic self-care practices by the nurses. Furthermore, I aimed to gain insight into how the healing opportunities were incorporated into practice, if these opportunities were supported by organizational structures and if self-care practices enhanced the nurses’ emotional wellbeing. Data analysis identified three key themes: the importance of self-care; aspects of palliative care affecting emotional wellbeing and counteractive self-care strategies.

The paper was developed from the data that has informed the third research aim. However, given the preceding discussions in Aim Two, the reader can expect to find some overlap in relationship to the content. Prior to reading, the aim and publication title are highlighted in figure 4.7 below.
Figure 4.7 Aim three  Themes on strategies that promote emotional wellbeing

Strategies utilised to promote emotional wellbeing

The importance of self-care

Aspects of palliative care affecting emotional wellbeing
  Emotional work and palliative care
  The emotional impact and stress of palliative care practice
  Young clients and palliative care
  Workplace challenges

Counteractive self-care strategies
  Self-validation and seeking emotional support
  Setting emotional boundaries
Journal article removed due to copyright restrictions. (pp. 233-244)

Holistic Nursing Practice

http://journals.lww.com/hnpjournal/pages/default.aspx

The publisher's version of this article is available at:

http://dx.doi.org/10.1097/01.HNP.0000339345.26500.62
Conclusion

Aim Three revealed the strategies the community health nurses utilised to promote and enhance their emotional wellbeing. Three themes emerged, that palliative care practice was demanding yet rewarding, however, the central theme of comfortability was critical to professional practice. The participants identified palliative care practice as having a significant emotional impact and counteractive strategies were necessary to enhance their emotional wellbeing. The importance placed upon holistic self-care by community health nurses is significant particularly as nurses face the ongoing emotional challenges associated with caring for recipients of palliative care.

Chapter Summary

This chapter has explored the three main aims related to this research with the intention of increasing my understanding of the lived experiences of women community health nurses who provide palliative care to clients living in a home environment in the community. Specifically I set out to investigate and explore the concept of emotional wellbeing, the relationship between emotional wellbeing and professional practice and the strategies utilised by the nurses that promote their emotional wellbeing.

I have demonstrated that emotional wellbeing was complex and multifaceted for the community nurses and was strongly associated with the notion of balance. The nurses identified that providing palliative care was complex yet was a source of job satisfaction. When considering emotional wellbeing, the nurses’ stories highlighted the relationship it held to balance. Feeling balanced was associated with self-awareness, the capacity to cope with the emotional work, spirituality and the nurses’ ability to set appropriate boundaries. These aspects all played an important role to support emotional wellbeing however, when nurses felt energetically depleted, they identified with feeling out of balance. The recalled stories described the links that existed between the emotional, physical and spiritual realms of the nurses’ lives.

The second and most complex aim, explored the relationship between emotional work, emotional wellbeing and professional practice. It became apparent that there was a pervasive interconnectedness between the work, wellbeing and practice. Analysis of the
data identified three main themes, demanding, rewarding and comfortability. Data analysis revealed fourteen interwoven elements that were immersed within and across the three themes. The first theme ‘demanding’ was associated with how the participants perceived many aspects of their role. The emotional work could be draining and at times stressful, particularly when organisational issues placed additional burden on the participants’ emotional wellbeing and drew deeply upon nurses’ energy reserves.

Yet the rewards were plentiful and were believed to promote and enhance participants’ emotional wellbeing. However at the heart of this third aim was the degree of comfortability the participants perceived to have. Comfortability was a key indicator of optimal client outcomes and participant wellbeing. Comfortability could be related to self-confidence, self-concept and feelings of empowerment and was strongly associated with decision making. For example, when nurses felt confident and comfortable in their capacity to provide psychosocial care to clients and their family, those issues were explored and nurses emotional wellbeing enhanced. Alternatively, when confidence was juxtaposed by feelings of inadequacy, a position of uncomfortability created reluctance for nurses to explore the sensitive client issues, thus client outcomes were compromised and nurses’ emotional wellbeing could be impaired. Analysis strongly demonstrated that whilst generalist palliative care was demanding, it was also rewarding. Yet extremely critical to the findings, was the nurses degree of comfortability the participants had in executing their knowledge and skills to promote professional practice and quality client outcomes.

The third and final research aim focused on the strategies utilised by the nurses that promoted their emotional wellbeing. The complex nature of palliative care provision by the community health nurses was revealed along with the emotional impact and the importance of self-care strategies utilised to promote and enhance their emotional wellbeing. Data analysis revealed three main themes: the importance of self-care; aspects of palliative care affecting emotional wellbeing; and counteractive self-care strategies. Self-care was found to be important to all participants, often identified as participants shared their stories related to the emotional impact and feelings of sadness, stress or being emotionally challenged. There was evidence that many aspects of practice had the potential to impact on the nurses’ emotional wellbeing. The emotional energy was often associated with psychosocial care, caring for young clients or addressing the frustrations from within the workplace environments. In order to counteract the negative impact, nurses
implemented self-care strategies to rebalance, empower, and self-nurture. Self-validation and assertiveness were positive interventions and seeking emotional support was critical. Nurses identified their need for debriefing and to set emotional boundaries primarily as a protective mechanism, yet clinical supervision was identified as the most preferred option. Whilst this was only available if privately funded, participants accessed colleagues, other health professionals or counselling support to promote self-care. Promoting self-care must be a shared responsibility. If nurses emotional work is to impact on their emotional wellbeing, then self-care is essential so that emotional wellbeing can be enhanced and professional practice sustained.

Palliative care practice was a rewarding role yet the emotional work exposed community health nurses to emotional vulnerability and wounding. Nurses’ stories were at times tearfully shared, affirming the deep impact some experiences had on their emotional wellbeing. Feeling sad, burdened, stressed, and emotionally challenged were terms used to describe their feelings. Nurses reported sleeplessness and feeling drained of their energy. Caring for clients facing end of life was emotionally demanding and significantly increased when caring for younger clients. In addition, workplace challenges such as lack of resources and heavy workloads could result in high levels of frustration and feelings of disempowerment. These feelings were compounded when nurses encountered problems with interpersonal communication, power and politics in the workplace, increasing the negative impact. The importance placed on self-care and the ways in which the nurses cared for themselves in order to care for others, was demonstrated. There was an emphasis on holistic self-care as the community nurses revealed the challenges encountered in their palliative care practice and the emotional impact.

Whilst the nurses identified the value of healthy lifestyle choices in supporting their emotional wellbeing, seeking out sources of emotional support were essential to address the varied workplace challenges they encountered. It was evident that the nurses placed importance of setting emotional boundaries in order to protect themself from becoming over-involved with clients, or affected to a point of emotional exhaustion. Palliative care exposed the community nurses to emotional wounding however, implementing self-care strategies was an empowering process for the nurses. To enhance their emotional wellbeing they primarily utilised methods of debriefing, however the emotional support that nurses strongly sought was professional supervision. These opportunities were limited and
left many nurses feeling undervalued whereas the nurses who were able to access private supervision, were empowered by the process.

The research findings have explored and made visible many critical aspects related to the generalist community nurse role in the provision of palliative care to clients living in the home environment. The participants who have willingly shared their insights and heartfelt experiences, have created new opportunities not only for themselves but moreover, for all community nurses and providers of palliative care. Whilst caring for the emotional wellbeing of community health nurses can be deemed as a shared responsibility between nurses and healthcare organizations, I would strongly argue that by revealing and validating the reality of the nurses’ experiences, related to their professional practice, has significantly increased the emancipatory potential for themselves and other palliative care nurses.

The next and final chapter will revisit the aims of this study and consider the research validity. With many insights gained, the chapter will discuss the implications for nursing.
Chapter Five

Conclusion: Reflections, insights and implications
Initiating closure

This research through an emancipatory approach, created visibility of the community health nurses’ experiences of emotional wellbeing and the relationship it held to their professional practice. In bringing this research to a close, it is important to reflect upon the study in terms of research process and design and the association between process, analysis and outcomes. The implications of the research to nursing practice will be discussed and future research opportunities outlined.

The chapter is divided into five headings, namely: fulfilling the research aims and question; methodological design, research process and rigour; study outcomes; implications to nursing practice; further research and dissemination; and closing thoughts. I begin by revisiting the research aims and question.

Fulfilling the research aims and question

This research was developed to explore and investigate community health nurses’ emotional wellbeing and its relationship to their professional practice. The study broadly aimed to extend an earlier study I conducted on wellbeing (Rose, 2002), wherein I explored the concept of wellbeing with community mental health nurses.

The current study was intentionally designed to explore the relationship between emotional wellbeing and professional practice of community health nurses, particularly as my clinical discipline area is community health. This study involved sixteen generalist community health nurses who provide palliative care to people living at home and myself as a research participant. As there was limited literature in this area, it was aimed that the findings of this study would contribute further to nursing knowledge. The research question was: What are the lived experiences of women community health nurses providing palliative care to clients in a home environment in relationship to their emotional work, emotional wellbeing and professional practice?

The study had three specific aims. The first aim explored the concept of emotional wellbeing with the community health nurses. The second aim investigated the relationship between the nurses’ emotional work, emotional wellbeing and professional practice. The
third aim explored the strategies utilised by participants to promote their emotional wellbeing.

In Aim One, data analysis found the concept of emotional wellbeing to be a multifaceted phenomenon that was deeply immersed in the unique subjective experiences of each participant. There was a strong interconnectedness with the emotional, physical and spiritual realms of each woman’s world, revealing the complexity associated with emotional wellbeing. The concept of balance was the most outstanding theme. The nurses recognised feeling out of balance or feeling emotionally unwell more readily before acknowledging that their emotional wellbeing was associated with feeling balanced. Similarly, in the previous study with community mental health nurses, the generalist nurses framed emotional wellbeing within the domain of client care. As stories unfolded, so emerged the value of emotional wellbeing and moreover, so did the relationship it held to their professional practice. These findings held similarities to the previous research that found emotional wellbeing a nebulous notion that was also associated with stress, inner balance and had an interconnected relationship between the mind, body and spirit.

The main findings for Aim Two were that palliative care practice was demanding whilst rewarding, yet of most significance was the comfortability the community health nurses had within their practice. The findings revealed a pervasive interconnectedness between emotional work, emotional wellbeing and professional practice. Within the interconnectedness were fourteen interwoven elements that fluidly moved across and within each of the themes.

Data analysis revealed the emotional work related to palliative care and the many stories that were shared were accompanied by emotional distress. Organisational and workplace issues increased the demands often expressed by feelings of frustration. The demands had the ability to impair the nurses’ emotional wellbeing. Whilst the demands were clearly articulated throughout the interviews, nurses equally shared the rewards related to their practice. The demands and rewards were of equal significance. Establishing relationships that were believed to make a positive difference to client outcomes were highly valued. Effective communication was at the core of all positive relationships, yet the rewards at times were juxtaposed by destructive relationships based on power and control. All of the participants were committed to their practice and believed that their contributions to
palliative care should be acknowledged. The most significant findings related to this aim were related to the third theme of comfortability. As I listened and re-listened to the stories it became clearly evident that the issue of comfortability, within palliative care practice, was the most critical issue. Comfortability affected care and had the potential to compromise or augment a client’s palliative process. When a nurse was comfortable, intrapersonally and interpersonally with the situation, the benefits for positive client outcomes and emotional wellbeing were present. Feeling comfortable did not necessarily relate to achieving desired outcomes but moreover, that nurses had given the best care possible at that time. Alternatively, if nurses felt inadequate in their ability, or limited by issues outside of their control, fewer opportunities for client healing took place and the nurses’ emotional wellbeing could be hindered.

The findings for Aim Three were that the community nurses considered self-care imperative to their practice. It was clearly evident that the community nurses were committed to palliative care provision yet, at times, a dialectical tension arose between caring for themselves and caring for others. The most critical form of self-care involved seeking emotional support. This was often addressed through informal debriefing. This did not invalidate the need for nurses to engage healthy lifestyles and use strategies that were empowering to support their immediate healing requirements. Community health nurses identified links both directly and indirectly between self-care and also their capacity to provide optimal client care. This finding concurred with the community mental health nurses. Self-care was critical to enhance their state of wellbeing to manage the work and home life interface and held significant relationship to providing optimal client care.

Data analysis of the research findings highlighted areas in professional practice which the community nurses held as valuable, demanding, rewarding, at times empowering and professionally satisfying, yet juxtaposed to that were experiences that were identified as disempowering and associated with stress, distress and professional dissatisfaction. The participants articulated a desire for additional support, education and professional development, all of which could lead to enhanced comfortability in their provision of palliative care. The community health nurses specifically identified the absence of formal clinical supervision as invalidating their professional contributions to palliative care provision. Clinical supervision was believed to be a process that would enhance their
professional practice and therefore, could benefit client outcomes. The other insights that 
arose from this study related to the methodological design and research process.

Methodological design, research process and rigour

The methodological design chosen for this qualitative study was critical social science and 
feminism. Both of the philosophies were underpinned by emancipatory objectives. Critical 
social science provided a lens to explore the community health nurses’ social world and 
create meaning of their subjective experiences. Feminist theory focused on the nurses' 
experiences of marginalisation and oppression, however of most importance was the intent 
to create an environment that valued the community nurses’ unique subjective experiences 
and to provide a framework for the nurses to speak out and be heard, thus validating the 
women’s voice/s. Both political paradigms worked in congruence to optimise the research 
process.

It was evident from the onset of this research that community health nurses were keen to 
participate in the study. Many participants strongly believed that, as generalist palliative 
care providers, their contributions were overshadowed by specialist Palliative Care Nurses, 
yet other participants regarded themselves as equal members of the palliative care nursing 
team. This perception could relate to some community health nurses holding palliative care 
postgraduate qualifications however, one of the strongest advocates for increased 
community health nurse visibility in palliative care was from an experienced Community 
Health Nurse who held advanced palliative care qualifications.

That notwithstanding, the issue of visibility and lack of respect and professional recognition 
of the community nursing palliative care role was meaningful and a cause of frustration for 
some. As previously outlined, the participants’ emotional wellbeing and its relationship to 
palliative care practice was significant for participants, yet often overlooked. Consequently, 
most participants identified the opportunity to participate in this study as valuable and 
important and an opportunity to make visible their subjective experiences.

In keeping with all qualitative research, I was mindful to ensure that the research process 
was rigourous. In this study the components of rigour were guided by the feminist process 
outlined by Hall and Stevens (1991). The process of reflexivity as a vital characteristic
within feminist research (Dowling, 2006) was utilised to promote research validity. Reflexivity requires that the Researcher remains aware of ‘self’ and attuned to any issues that could influence the project (Etherington, 2004). Therefore, my dual positions of researcher and participant were made clear at the onset of this study and my participation, along with any potential bias that could influence the content and/or the process, were clearly outlined. Within reflexivity is the capacity for introspection. Introspection and reflexivity involves self-awareness and, as Koch and Harrington (1998) suggested, an unremitting engagement in the processes of self-critique and self-appraisal. My introspection was primarily through the use of a reflective journal. In this journal I was able to document my reflections of my thoughts, feelings and behaviours associated with the study. This was also a useful tool for my own therapeutic healing (Glass, 2007).

The interview process adopted a shared approach that was non-hierarchical. I remained open and honest at all times with the participants and willingly shared by own personal and professional experiences as appropriate. I believe that this was important within the interview process as it promoted equality and fostered a position of safety, in which the women were supported to speak freely.

Research credibility refers to the true representation of the participants’ shared experiences. Hall and Stephens (1991) believed that if participants are able to recognise the stories as their own, then credibility and authenticity have been achieved. To ensure credibility I personally transcribed the majority of the audio-recorded interviews. Due to time limitations, I employed an experienced research transcriber to assist with the minority. Upon receipt of the transcriptions, I listened to the audio recording whilst comparing the transcribed copy. This ensured that I was able to make any necessary alterations. The transcriptions were kept as working documents, as the audio recordings that had been converted to CD were individually returned to the participants for member checking. Upon follow-up with each participant, no changes were requested; therefore the transcriptions were regarded as accurate sources of data.

Establishing a rapport with the participants was considered by Hall and Stevens (1991) as another measure of validity. It was also necessary to promote an environment that was based on trust and safety. Following informed consent from the participants, it was important to discuss various options in regard to conducting the interview. It was critical
that each participant chose a place that was deemed emotionally safe to them. As this research was conducted across a wide geographical area, it was necessary to ensure that the place of choice was suitable for the participant. Some of the interviews were conducted in clients’ home environments, whilst others were held in offices and public cafés. Whilst the final choice was mutually agreed, the cafés proved the most challenging primarily due to external noise. With that said, the conversations were enriched by mutual understanding and validation. The conversations and stories shared were meaningful and valuable. I endeavoured at all times to remain physically and psychologically present with the participants during any time of emotional distress. Additional emotional support was offered to the participants and names of counselling services given if required. My reflective journal was personally healing during these situations. For instance, on one occasion I entered:

*I struggled unsuccessfully today to hold back tears as Shae shared heartfelt stories of dying children. The emotional strength required by a nurse to remain present and focused while caring for a young client and their family is huge. During our interview Shae collected a toy from her shelf. She shared the stories, joy, laughter and meaningful events that accompanied the toy. It clearly triggered past experiences. A client can be long passed, however the emotional impact and significant memories live on. It’s not the tears that are a problem. Tears carry meaning, compassion and humanness. It’s what the tears represent that requires reflection.*

Another aspect of rigour is the complexity of reality associated with the research (Hall & Stevens, 1991). Each community nurses’ subjective experience was valued and reflected the complexity associated with their unique socio-political positions. All of the nurses were invited to share their experiences related to emotional wellbeing and their professional practice. It was intentional that this process would provide an opportunity for the women to speak out, reflect on their encounters and create meaning to their stories. With the research questions being semi-structured in nature, this provided increased opportunities for each participant to expand on their stories, to enhance understanding and construct meaning.

Relevance of the research is another aspect of rigour that is highly regarded in feminist research. Relevance is concerned with the appropriateness and significance of the research in relation to women’s concerns and interests (Hall & Stevens, 1991; Webb,
This research focused on exploring and investigating women community health nurses’ experiences of emotional wellbeing and the relationship it held to their professional practice. The process valued and validated the women’s subjective, unique, lived experiences associated with their professional roles. These issues were addressed significantly within Chapter Four.

It was also the intent of this research to attempt to make a difference to the nurse and nursing, just as the participants hoped to “make a bit of a difference to peoples lives”. The community health nurses were keen and “happy” to volunteer to participate with one nurse stating she “would relish the opportunity”. The feedback following the interviews varied from acknowledgement and appreciation to more value laden responses such as “I’ve enjoyed it because I’ve been able to verbalise a few things. I jumped at the chance because I thought it was a fantastic [study]”. Nurses asked to be kept up to date with the research progress.

This research provided the means by which participants’ experiences could be disseminated across the nursing profession in the hope of having their voices heard, their experience acknowledged and their palliative care roles made visible. All participants were advised that the findings would be disseminated within refereed nursing journals and at relevant conferences. Over the duration of this research and through thematic analysis, I have endeavoured to create awareness of the community health nurses’ experiences with palliative care provision. In addition to the journal articles I have co-authored with my Supervisor, Associate Professor Nel Glass, two peer reviewed conference papers were presented at relevant State conferences (Appendices 4 & 5). When all the articles are published, copies will be forwarded to each participant to additionally validate the valuable contributions they have made to advancing nursing knowledge and creating emancipatory opportunities.

**Study outcomes**

To demonstrate the epistemological and ontological links associated with the methodological framework I have addressed this in two sections: *what has been achieved*; and *what I expect to be achieved*. 
What has been achieved

It is important to reflect on the emancipatory approach that was implemented to support the research process. Emancipatory frameworks provide a lens through which issues of marginalisation and oppression can be addressed and transformative opportunities created. The published article included in Chapter Three of this thesis entitled: ‘The importance of emancipatory research to contemporary nursing practice’ (Rose & Glass, 2008) discussed the methodology and its congruence to this research. Applying a critical feminist lens enhanced opportunities to acknowledge, value and validate the women’s individual and collective voices.

The community health nurses were well positioned to critically examine their work environments and explore the issues that could limit or enhance their emotional wellbeing and professional satisfaction. The participants shared their rewarding experiences associated with job satisfaction and their issues that resulted in job dissatisfaction that could hinder their wellbeing. The nurses were optimistic that, through sharing their subjective experiences, their professional visibility could improve and that the potential for transformative outcomes for community health nursing could be achieved for the benefit of all. The participants also recognised and verbalised the need for change and sought to be recognised by other health professionals for their contributions to palliative care, whilst simultaneously making visible many key issues related to their complex and emotionally demanding roles.

I believe that the emancipatory framework applied to this research was valuable as it aimed to raise the consciousness of the community health nurses, and create opportunities for transformation and change. Applying a critical feminist approach provided a basis where the socio-political positions held by the participants could be examined and critiqued. Feminist principles enhanced the process by giving voice to the women, supporting them in environments that were considered emotionally safe to feel able to speak openly about their experiences and share their meaningful stories in the hope of creating change. This approach was politically aligned with my epistemological and ontological position as a woman and nurse and supported my belief that women and nurses experience varying degrees of marginalisation and oppression. I believe that applying this methodological
approach to this research has validated the important role that community health nurses have in palliative care provision.

What I expected to be achieved

When I consider the commitment and passion associated with the contributions of community health nurses to individuals and families requiring generalist palliative care, I maintain hope for positive change. On an individual level, I believe that the research process was valuable on both a personal and professional level. Not only were the nurses provided with opportunities to speak out and be heard but moreover, were personally acknowledged that their issues and concerns were not isolated, with many experiences and feelings shared by other generalist community health nurses. During correspondence with participants following the interviews, nurses expressed their thoughts related to being involved in the study. One nurse wrote, “looking forward to your continuing and very valuable research”.

On a broader level I anticipate that through the dissemination of the findings through peer reviewed journal publication, that all community health nurses, Nurse Managers, palliative care providers and educators both nationally and internationally will benefit. This is not to deny the challenges that currently face nursing world wide, nor the increased demand placed on nurses due to nursing shortages and fiscal policy. However, without qualitative research that explores and investigates nurses’ subjective experiences related to practice, the advances in nursing practice are limited. With an ageing population in Australia requiring community based care and an ageing nursing population providing the care, it is critical that research exploring the relationship between nurses’ emotional wellbeing and professional practice is undertaken.

Implications to nursing practice

This study was valuable in making visible many important issues that are critical to improving the professional practice of community health nurses who provide palliative care. The implications that could be considered focus on palliative care education and professional development that could enhance nursing knowledge, palliative care nursing skills, develop confidence in care provision whilst building nurses’ self-concept as care
providers. One positive step involves further consideration of the value of clinical supervision for all palliative care nurse providers. Whilst this is considered mandatory for specialist nursing teams, the community health nurses in this study clearly perceived supervision as a process that would enhance reflective practice and improve professional practice. Collaborative discussions with community health nurses regarding their needs would be a positive step forward, particularly as nurses are under pressure to achieve quality client outcomes.

A strong association between emotional wellbeing and self-care arose from this study. It is believed that from a holistic standpoint that the importance of personal health and wellbeing could be incorporated as mandatory training for all community health nurses. This simultaneously would promote the value of self-care, where continued support and health promotion could be provided by organisations to enhance the nurses’ emotional wellbeing in all nursing workplace environments. These implications create new opportunities for further research.

**Further research and dissemination**

This qualitative study was undertaken with generalist community health nurses. The study was narrowed further as it focused on the participants’ emotional wellbeing in relationship to palliative care provision. Due to the limitations of the inquiry, it opens opportunities for broader research opportunities that could incorporate qualitative, quantitative or mixed method research to advance our understandings in new ways. In addition, the broader community health nursing sector is expansive and research relevant to exploring their experiences of wellbeing and professional practice are encouraged. There is always more to learn in regard to nurses’ experiences in the workplace and the issues that enhance or hinder their professional satisfaction.

It is not possible to generalise the findings of this research and it stands alone in capturing a moment in time for the all of the women community nurse participants. Any future study with generalist community health nurses would be proposed as post-doctoral research and has yet to be considered. I feel that it is important to acknowledge that over the past four years, a growing body of knowledge developed in regard to the emotional health and wellbeing of nurses. However this research inquiry is now complete and whilst it has
achieved its aims, emancipatory outcomes have been made possible. In bringing this study to a close I offer the following thoughts.

**Closing thoughts**

This research has raised awareness of the subjective experiences of the community health nurse participants from New South Wales, Australia. The findings identified multiplicitous issues that could result in the nurses being professionally satisfied or dissatisfied. Palliative care practice was a complex and demanding role that placed generalist nurses in emotionally vulnerable and challenging situations that could impact significantly on their emotional wellbeing. Palliative care practice was also a rewarding role, yet community health nurses’ level of comfortability with palliative care practice varied significantly. Comfortability in palliative care was central to community health nurses’ emotional wellbeing and client outcomes, and thus sits firmly within the heart of professional practice.

To enhance their emotional wellbeing, it was essential that nurses implement self-care strategies and accessed support, yet gaps in organisational support existed. The emancipatory approach applied to this study was an important process. The feminist approach enabled the community health nurses to have their voices heard and most importantly, valued and validated. The findings that arose from this research have implications for the future of community health nurses, the nursing profession and the recipients of care.

This study has succeeded in achieving the three research aims as discussed in Chapter Four and subsequently has comprehensively answered the identified research question. An outcome of critical importance is that actions for positive change have been created and emancipatory outcomes now made possible. Whilst this study is considered complete, further areas for research have been suggested. In the words of one community health nurse, “the potential could be Pandora’s box”.
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Appendices
Appendix one

University Human research ethics approval
SOUTHERN CROSS UNIVERSITY
~ MEMORANDUM ~

To: N. Glass/J. Rose
Nursing and Health Care Practices
nglass@scu.edu.au
jrose1@scu.edu.au

From: Secretary, Human Research Ethics Committee

Date: 14.3.05

Project: Emotional work, emotional wellbeing and professional practice: the lived experiences of women community health nurses providing palliative care in the home environment.

Status: Approved subject to standard conditions of approval and some special conditions
Approval Number ECN-05-17

HUMAN RESEARCH ETHICS COMMITTEE (HREC)

Thank you for your application to the Human Research Ethics Committee.

At the meeting of the HREC on the 7 March 2005, this application was considered by the full Committee. This application was commended by the Committee. The researchers are requested to give approval to the use of this application as an exemplar application for other researchers. Would the researchers please forward their permission to the Secretary, HREC.

This project has been approved subject to the usual standard conditions of approval and the following special conditions.

Compliance to the special conditions is mandatory to the approval and the compliance is required within one month of the approval. Please send all correspondence to the Secretary. Please contact the Secretary if the compliance cannot be provided within one month.

Please return the signed certification (attached) with appropriate signatures any specific documentation to the Secretary when you have complied.

Special Conditions
(a) Informed Consent Form – please include the signature of the researcher.
(b) The Committee recommends that ‘a feminist approach’ be included in the information sheet.
(c) At Question 20 – the answer to this question should be YES, as the approval of the NRAHS is necessary. The SCU HREC approval is contingent on the receipt of the NRAHS Ethics Committee approval.
(d) The Committee would like the researchers to re-qualify Indigenous people being included in this
research.
(e) Please proof-read the Information documentation.

(f) It is suggested that the Ethics Approval Number be included in the consent information. For example:
*This research has been approved by the Human Research Ethics Committee at Southern Cross University. The approval number is ECN-05-176.*

(g) Please note that the standard University complaints paragraph has been updated. Please include the following on appropriate documentation to participants:
*The ethical aspects of this study have been approved by the Southern Cross University Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Ethics Complaints Officer, Mr John Russell, (telephone [02] 6620 3705, fax [02] 6626 9145, email: jrussell@scu.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.*

**Standard Conditions** (in accordance with *National Health and Medical Research Council Act 1992* and the National Statement on Ethical Conduct in Research Involving Humans):

1. That the person responsible (usually the Supervisor) **provide a report every 12 months** during the conduct of the research project specifically including:
   
   (a) The security of the records
   (b) Compliance with the approved consents procedures and documentation
   (c) Compliance with other special conditions.
   (d) Any changes of protocol to the research.

   Please note that compliance to the reporting is mandatory to the approval of this research.

2. That the person responsible and/or associates report and present to the Committee for approval any **change in protocol** or when the **project has been completed**.

3. That the person responsible and/or associates report immediately anything that might affect ethical acceptance of the research protocol.

4. That the person responsible and/or associates report immediately any adverse effects on participants.

5. That the person responsible and/or associates report immediately any unforeseen events that might affect continued ethical acceptability of the project.

6. That subjects be advised in writing that:

   The ethical aspects of this study have been approved by the Southern Cross University Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Ethics Complaints Officer, Mr John Russell, (telephone [02] 6620 3705, fax [02] 6626 9145, email: jrussell@scu.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.
CERTIFICATION  
ECN-05-17 – Glass/Rose - March 2005 meeting

Emotional work, emotional wellbeing and professional practice: The lived experiences of women community health nurses providing palliative care in the home environment.

Please return the following certification when the special conditions have been addressed. Include a copy of your changes so that the Committee can note the changes at the next HREC meeting.

Certification

Conditional approval will lapse one calendar month from the date of this memorandum if the special conditions have not been fulfilled, and thereafter the University will not accept any further responsibility in regard to the research.

If special conditions have been imposed, you must complete this and return it to the Graduate Research College by the lapse date. Please notify the Secretary if timing is a problem.

I certify that the special conditions outlined above have been fully met, a copy is attached, and that the standard conditions will be met.

Signature of Researcher: ________________________________  Date: 28th March 2005

..........................................................
Appendix two

Participant consent form
Consent Form

I

of

hereby consent to be a participant in a human research project, to be undertaken by Jayln Rose entitled ‘Emotional wellbeing, emotional work and professional practice: the lived experiences of women community health nurses providing palliative care in the home environment’.

The research and my involvement in it have been explained to me and any questions or concerns have all been answered to my satisfaction. I understand that the research involves one tape-recorded interview with Jayln Rose during which I will be asked to share my thoughts, feelings and experiences regarding my emotional wellbeing and professional practice.

I further acknowledge:

- I voluntarily and freely give my written consent to participate in this research project.
- I am over 18 years of age.
- The aims, methods, and anticipated benefits and potential risks of this research have been explained to me.
- I will participate in one tape-recorded interview approximately 1 hour in duration with Jayln Rose.
- As the research topic may arouse feelings of discomfort or distress, I may request that the tape recorder be turned off at any time and/or the interview ceased.
- I will be given a typed transcript of the interview in order to make any corrections, changes and/or deletions that I may feel necessary.
- My name and any details that may individually identify me will be changed in order to protect my privacy and maintain anonymity.
- As my participation is voluntary, I am free to withdraw from the project at any time.
- I understand that the results of the whole study will be used for research purposes and may be reported in professional journals and/or at professional conferences.
• I am able to freely contact John Russell SCU Ethics complaints officer if I have any ethical concerns with this project (email jrussell@scu.edu.au Telephone 0266203705).

Signature ............................ Date ......................................
Appendix three

Participant information sheet
Hi my name is Jayln Rose and I am a registered nurse currently enrolled in a PhD in the School of Nursing and Health Care Practices at Southern Cross University, Lismore. I am currently undertaking a nursing research project entitled ‘Emotional wellbeing, emotional work and professional practice: the lived experiences of women community health nurses providing palliative care in the home environment’ and the purpose of this information sheet is to provide you with some details of my study.

As you are probably aware, there remains a longstanding acceptance of the significant relationship between emotions and nursing and more specifically, occupational stress and burnout. It is my experience as a community health nurse that nurses working in the community environment are increasingly involved in providing palliative care to clients which exposes them to and potentially challenging situations that may impact on their emotional wellbeing. I believe it is important to note that not all community health nurses are formally trained in palliative care and this emotionally demanding clinical role has the potential to cause an increased degree of stress for some. It is my intention that this research will expand upon the findings of a previous study undertaken by me in on emotional wellbeing and professional practice in 2002. It is anticipated that this project will allow health professionals to gain a greater insight into the impact of emotional work on nurses wellbeing.

The purpose of this information sheet is to provide you will details of this research project and more importantly, to invite you to participate in the research.

In terms of the research, I will be inviting women registered nurses who are currently working in community health and more specifically involved in providing palliative care to clients living in the home environment to participate. I plan to have 10 volunteers and will be interviewing each nurse individually. I anticipate that the interview process will take approximately 1 hour in duration and will be held at a mutually agreeable location. During
the interview I will be asking you questions that are related to your emotional wellbeing, for example ‘what does emotional wellbeing mean to you?’ as well as issues that are associated with your professional practice such as: what factors impact positively and/or negatively upon your emotional wellbeing? I will also investigate the importance of communication, means of support and self-healing/self-caring practices that may utilise for your own health and wellbeing. I will give you the interview questions prior to the interview so you will have time to reflect on those questions being asked which may prove more comfortable for you.

Your privacy, confidentiality and anonymity will be protected throughout the entire research process. Your name will be replaced with a pseudonym as will all identifying places. All of the collected interviews will be transcribed by me and returned to you for checking of accuracy allowing you to make any necessary changes or deletions. All of the collected interviews will be kept for a period of 5 years and secured in a locked cupboard only accessible by me.

Due to the sensitive nature of the research topic you may experience emotional distress as a result of sharing your thoughts, feelings and experiences. I will endeavour to minimise any distress and remain as supportive as possible throughout the interview. You may request at any time to have the tape recording stopped, and only recommenced when you feel ready. Should you require any further emotional support I will provide you with a list of counsellors.

Participating in this research is entirely voluntary and therefore you are free at any time to withdraw from the project without consequence. Should you decide to participate, a written consent form is attached and this will need to be completed and returned to me before the interviews can be arranged. If you have any further questions or require additional information please contact me by phone or email (details provided above) or my supervisor Associate Professor Nel Glass on Ph 02 66203674 email nglass@scu.edu.au.

Thank you for taking the time to consider this opportunity.

With regards,

Jayln Rose.
Appendix four

Conference Presentation

NSW State Palliative Care Conference

Unexplored Territory

Orange NSW, Australia

2-3rd November 2006

Getting to the heart of the matter: Community nurses speak about providing palliative care and their compelling need for emotional support.
Presentation Letter of Offer: Palliative Care New South Wales

Jayln Rose
Department of Nursing & Health Care Practices,
School of Health & Human Sciences
Southern Cross University
PO Box 157
Lismore
NSW 2480

3rd October 2006

Dear Jalyn

Thank you for your abstract submission. I am pleased to offer you the opportunity to present your oral paper: Title: Getting to the heart of the matter: Community Nurses speak about providing palliative care and their compelling need for emotional support. At the forthcoming palliative care conference in the Thursday 2nd November afternoon concurrent session, Lessons from the field.

Please note:
• All presenters will be required to register for the conference and pay the concessionary presenters registration fee of NSW Palliative Care Association members $300 and non members $330
• You will be required to make your electronic presentation available to a member of the organising committee by 08.00Am on the morning of your presentation at the venue

Please confirm your acceptance of this offer ASAP.

Yours Sincerely

Michelle Davies
Organising Committee
Greater Western Area Health Service
Getting to the heart of the matter: Community Nurses speak about providing palliative care and their compelling need for emotional support

Jayln Rose
PhD Candidate Department of Nursing and Health Care Practices, Southern Cross University; RN North Coast Area Health Service

Associate Professor Nel Glass
Department of Nursing and Health Care Practices, Southern Cross University

Research Aims & Significance

• explore the lived experiences of women community health nurses who provide palliative care to clients in the home environment

• focus on emotional wellbeing and its relationship to professional practice

Research Design

Model

Research Design

• Methods
  – Semi-structured interviews
  – Reflective Journalling

• Participants
  – NSW
  – Rural & Urban
  – 15 Community Nurses

Contemporary Literature

• Community Nursing Palliative Care

• Palliative Care

• Community Nursing
Research Data Overview

• Providing palliative care

• The compelling need for emotional support

Providing palliative care

• Educational needs

• Professional boundaries

• Intra/Interpersonal communication

• Professional supervision

The compelling need for emotional support

• Emotional practice - the personal impact

• Reaching out- formal/informal support

• Self care - creating balance

• Professional supervision

Providing palliative care

• [The clients] are mainly asking for support, someone to listen…sometimes I don’t know what to say and sometimes [I’m] crying as much as they are (Rita).

• [It’s] difficult to maintain clinical distance if you’ve been involved before…I actually find I need to talk about things (Amelia).

Providing palliative care

• Not getting involved… not taking too much on board. That’s probably the hardest thing for me… Its quite emotionally demanding work (Joy).

• Its not the person you are looking after that is the challenge but its quite often the relatives…[and] if other people in the team are not emotionally stable either then that’s hard! (Di).
The compelling need for emotional support

- It's like you've taken some of the load off [the clients] shoulders and put it on yours. You walk out feeling like a 'rung out rag'! (Tishe).

- I would wake up in the morning feeling like I had clenched my teeth all night. I couldn’t eat, I couldn’t sleep properly…It was hideous!… I’ll never forget it as long as I live (Tishe).

The compelling need for emotional support

- I was crying and I would think about her…so I don’t know if I have had closure…I don’t know how to do that…How do you deal with it?… I find [palliative] really stressful… it’s such an emotionally charged time… this is bringing up tears' (Kay).

Improving practice: relieving the emotional impact

- Theoretically there is meant to be [supervision] but there's not… we've got a PC social worker [who] I feel like I can go and talk to and I do sometimes (Sarah).

- I think there needs to be recognition that [CNs] do need clinical supervision, I think its very important! I started to validate and recognise myself as being important (Rosemary).

Improving practice: relieving the emotional impact

- We don’t have any clinical supervision which is a huge gap I feel. We have each other. We laugh together and cry together and that’s how we survive emotionally (Tiche).

- [I've] actually gone privately to supervision… because there is not the infrastructure, there has never been the recognition or the infrastructure put in place for nurses… I was able to hear what I was saying, reflect on my practice, which is why I went in, because its about moving on from that (Lee).

A good support network is essential!
Appendix five

Conference Presentation

The 4th Biennial NSW Primary Health Care, Research & Evaluation Conference.

Bondi, NSW

29-30 November 2007

Community nurses experiences: Navigating the emotional journey of palliative care provision.
Letter of Offer:

8 October 2007

Ref: 926

Dr. Nel Glass  
Associate Professor Department Of Nursing And Health Care Practices  
Southern Cross University  
PO Box 157  
LISMORE NSW 2480

Dear Dr. Glass

Submission of Abstract for the 4th Biennial NSW PHC Research & Evaluation Conference

On behalf of the Organising Committee, I am pleased to advise that the following abstract(s) has been accepted for oral presentation in the Conference Program:

Title: Community Nurses experiences: Navigating the emotional journey of palliative care provision. Session: Concurrent Paper S6 - Health Services

Delivery 30/11/07 1500-1630

Authors:  Jayln Rose Nel Glass

Presenters: Jayln Rose Nel Glass

Please check that all the above details are listed correctly, as they will be included in the Conference Handbook. Please notify us of any changes required as soon as possible.

A lectern, lectern microphone, data projector, projection screen and laptop with Microsoft PowerPoint software will be provided in each presentation room. Please advise if you have any additional audiovisual requirements (eg lapel microphone, Macintosh compatible computer or alternative software).

If you plan to use PowerPoint during your presentation, can you please email a copy of your presentation to <mailto:renae@conlog.com.au>renae@conlog.com.au by Monday 19 November 2007 and bring a copy with you to the Conference, either on CD-ROM or USB/Flash drive.

All presenters must register and pay to attend the Conference. If you have not yet registered for the Conference, you may register on line using the link
If you have any difficulties in fulfilling these requests please contact either myself or Renae Shepherd at the Conference Secretariat on 02 6281 6624 or email <mailto:conference@conlog.com.au>conference@conlog.com.au.

The Organising Committee congratulates you on the quality of your abstract and looks forward to your participation at the Conference.

Yours sincerely

Elizabeth Medley
Conference Manager
C/- Conference Logistics
PO Box 6150 Kingston ACT 2603 Australia
T: + 61 2 6281 6624  F: + 61 2 6285 1336   E: <mailto:conference@conlog.com.au>conference@conlog.com.au
Community Nurses experiences: Navigating the emotional journey of palliative care provision.

Jayln Rose  
PhD Candidate Department of Nursing and Health Care Practices, Southern Cross University

Associate Professor Nel Glass  
Department of Nursing and Health Care Practices, Southern Cross University

Presentation Overview
• The research aim
• Research design
• Emotional wellbeing
• Navigating the emotional journey
• Concluding thoughts

Research aim
• To explore the lived experiences of women community health nurses who provide palliative care to clients in the home environment.
• Specific foci:
  ❖ the concept of emotional wellbeing
  ❖ the relationship between emotional work, emotional wellbeing and professional practice
  ❖ strategies utilised by the CNs that promote their emotional wellbeing

Research design
  – Methodology
    • Critical Social Science
    • Feminist Theory
  – Methods
    • Semi-structured interviews
    • Reflective journaling

Participants
  • NSW Registered Community Nurses
  • Geographical locations: Rural & Urban NSW
  • Women participants = 15
  • Skill mix
Results:
Navigating the emotional journey
  • the relationship between emotional work, emotional wellbeing and professional practice

Navigating the emotional journey
  • Emotional Wellbeing

Navigating the emotional journey
  • Critical partnerships

  • Support

  • Dialectical tension: Satisfaction vs frustration

Critical partnerships
  • The whole process of what I had been able to do for them as a family group, that’s what I really got a kick out of (Haley).

  • The relationships within a family, even the husband and wife relationship, sometimes you’re so involved its like you’re the third party of the marriage! (Shae).

  • I see our role as being the main case manager with the lovely position of being able to call in the support of the PC if they need hospital admission or if you run into stumbling blocks we have the PCCSN (palliative care community specialist nurses) who we can call (Taylor).

  • Some GPs are really good to work with collaboratively, where other GPs are quite the opposite… it breaks my heart…so [its] very frustrating (Sarah).

Support
  • [The clients] are mainly asking for support, someone to listen…sometimes I don’t know what to say and sometimes [I’m] crying as much as they are (Rita).

  • We don’t have any clinical supervision which is a huge gap I feel. We have each other. We laugh together and cry together and that’s how we survive emotionally (Tiche).

  • I think there needs to be recognition that [CNs] do need clinical supervision, I think its very important! (Rosemary)

Dialectical tension: Satisfaction vs frustration
SATISFACTION:
  • If you’ve put all the work you can into it, it’s actually very satisfying and its also a privilege (Betty).
• You can’t save the world and I’m okay with that. If I can look back and think I helped that person and they were calm and peaceful, then that’s all that matters (Anna).

• A few times I’ve come home and said ‘God I hate this job’. But I really feel that it’s the best job I’ve ever had (Joy).

Dialectical tension: Satisfaction vs frustration
FRUSTRATION:
• I get frustrated with the inequity in health that it’s not a user friendly service not when it’s under resourced because there is nothing to give the clients… I’m frustrated with the fact that I can’t give the care that I would like to give (Lee).

• It’s very frustrating because you know that you can identify what [the clients] need but you can’t access the resources for simple things... Well they’re dying. Would it be so much to have a pressure mattress so that their last few days aren’t uncomfortable! (Amelia).

Concluding thoughts
• I would like more respect for my knowledge and profession from my manager, colleagues, GPs and other service providers (Sarah).

• I would like my line management to have more insights into the level of care, the depth of care and acknowledge the emotional aspects of the PC role (Shae).

• The CNs never really get recognised for what they do, it’s always the specialist PC teams that get recognised and that really pisses me off! (Rosemary).

Concluding thoughts
• I feel that [PC] brings everyone to an equal table, money can’t buy your health. I go home and say ‘thank God I’m well’ (Rita).