Thriving despite adversity:
Job engagement and self-care among community nurses

Hege Forbech Vinje

Dissertation for the degree philosophiae doctor (PhD)

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Department of Education and Health Promotion
Faculty of Psychology
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Hege Forbech Vinje

FOREWORD

The theme of this study has its roots in my own experience of leadership and organisational development in health care organisations. Leadership competence in learning organisations was my particular area of interest for many years. As a nurse and leader I met many engaged, compassionate and skilful nurses who were highly motivated and who were committed to their work. At the same time I also met a lot of fatigue and tiredness among the nurses, the toughest and saddest to witness were nurses who gave up nursing for a new profession. After several years as a leader in community health care, I came to a point where burnout was near for me as well. The symptoms of exhaustion were many and they resulted in sick leave. Reflecting on my way of life, it became clear that prioritising and making choices were necessary, and that changes were needed. I found that there was no easy way out. Severe self-scrutiny was required. This process changed the way I looked upon work, and an interest for what may be called a 'health promoting life-practice' was awakened.

Every community health care service has the same mandate, to offer health care services that contribute positively to the health of inhabitants in different ways. All inhabitants have the right to be seen, heard and understood, and they have the right to expect competent health care service at all levels, including health promotion, preventive care, active treatment and therapy, and supportive/palliative care. That community health care nurses have the competence necessary for their work, is a basic premise. Yet there is a paradox in the relationship between the nurses' own health and the health of the recipients of their care. Three questions arose from considering the mandate of community health care and my own experience: 1) how can community health care be trustworthy if it is not capable of maintaining and enhancing the health of its own workers? 2) how can the healthcare a nurse offers be trustworthy if he or she is not capable of maintaining and enhancing his or her own health? and 3) to what extent is the quality of a nurse's healthcare provision dependent on that nurse making good choices for his/her own health?

In the Spring of 2000 I received my professional degree in nursing sciences. In my thesis I studied leadership competence in nursing homes, with the purpose of exploring the conditions for developing nursing homes in community health care as learning organizations . The study was part of a national project led by Professor Marit Kirkevold, Institute of Nursing Sciences,

University of Oslo (Kirkevold et al., 1998). During this work I found that a learning environment has the potential of being health promoting. The co-workers' awareness of purpose, values and visions seemed to be of importance to work-place health and well-being (Gauthier, 1995; Senge, 1991; Zohar, 1997). A mutual focus on intra- and inter-personal levels seemed to be vital in order to activate the health promoting effect (Vinje, 2000). My interest in exploring these possible health promoting processes on an individual level was thus awakened and my personal experience combined with professional wondering became the urge and the inspirational force for this dissertation.

LIST OF PAPERS

Paper 1

Vinje, H. F. & Mittelmark, M.B (in press). Community nurses who thrive: the critical role of job engagement in the face of adversity. *Journal for Nurses in Staff Development*

Paper 2

Vinje, H. F. & Mittelmark, M.B (2007). Job engagement's paradoxical role in nurse burnout. *Nursing and Health Sciences.* Vol 9, pp 107-111

Paper 3

Vinje, H. F. & Mittelmark, M.B (2006). Deflecting the path to burnout among community health nurses: How the effective practice of self-care renews job engagement *The International Journal for Mental Health Promotion*.Vol 8 (4), pp 36-47.

ABSTRACT

Background: Community nursing in Norway has become an increasingly stressful occupation and many nurses who experience symptoms of burnout leave the profession. Yet others manage to cope with the adversity of nursing. This study addressed the question 'how and why do nurses in community health care experience job engagement and stay healthy – and what can we learn from those who succeed?' The assumption underlying this study was that job engagement is health promoting, and the intention was to study how and why community nurses can thrive despite the burdens of nursing. The idea was that if we could better understand nurses' job engagement, we might be able to suggest ways in which to help all community nurses to thrive.

Objective: The main objective of this study was to explore, in-depth, the nature of job engagement among thriving community health nurses and to investigate how job engagement may be maintained and promoted. Job engagement was understood to consist of three basic phenomena: "calling", "zest for work" and "vitality," all of which required in-depth exploration. This was done by conducting one empirical in-depth interview study and qualitative content analysis addressing the questions and aims of the study.

Design: The study used an explorative qualitative design, positioned as phenomenological research in relation to its philosophical approach of being concerned with the nurses' life-worlds, while methodologically it also drew on hermeneutics. The data were collected through 15 tape-recorded interviews that took between forty-five minuets to two hours, and were conducted in the interviewees' workplaces or homes. A thematic interview guide was modified from interview to interview, but the opening question was always: "Can you please tell your work-life story?" Fourteen interviews were transcribed verbatim and the nurses read and approved the transcriptions. The fifteenth interview was recorded, but could not be transcribed due to an equipment failure. The data from this interview were recaptured as well as possible from notes taken after the interview. A qualitative content analysis was conducted with both descriptive and interpretive approaches. The analytic tool evolved throughout the project. Five analytical steps were undertaken: 1) Gaining a general impression of the interview; 2) Dividing the text into fragments of meaning (meaning units); 3) Transforming the meaning units; 4) Meaning condensation and the creation of codes and categories and; 5) Searching for themes, understood as the expression of latent content. The analysis consisted

of analysing each participant's story and each issue and theme across participants and was conducted with a combination of case-focused, cross-case and issue-focused analysis. Further, the analysis proved to be a spiral-like process where I repeatedly and cyclically moved between steps and between cases, and between working with the transcribed interviews and reading literature on topics related to the phenomena being studied.

Findings: In addressing research question 1: 'How do thriving nurses experience job engagement?', I explored job engagement among community nurses who were thriving at the time they participated in the study, and the processes that promoted job engagement among these nurses (presented in paper 1). The analysis revealed that the nurses had high level of ethical standards and that a sense of calling was a core aspect in all the nurses' lives, something which they expressed through their nursing practice. The analysis also revealed a relatively enduring pattern of introspection and reflection, including deep attention to meaning, meaningfulness, and values connected to challenges at work, their experience of job engagement and their attempts to promote and maintain it. The concept of 'meaning' in and of life emerged as highly essential in the nurses' experience of job engagement, and that helped to crystallise the job engagement construct, in which the search for meaning, the experience of meaning, and holding on to meaning has the force of a drive. The analysis thus revealed that job engagement was experienced by these nurses as a process driven by the search for meaning, the experience of meaning and the holding on to meaning. Job engagements' motivational factor was a sense of calling and the calling/vocation match. Its fundament was the talent and habit of introspection and reflection.

The findings indicate that to promote job engagement, acknowledgment of the importance of values and possible value conflict between the person and the workplace is vital, both before a choice of profession is made and on a relatively continuing basis during one's work life. The data illustrated that it is possible to make introspection and reflection about values and the meaning of work an integral part of working life. On the basis of the entire analysis and interpretation, it is concluded that staff development and vocational guidance work should include explicit recognition of, and attention to, the importance of a nurse's awareness of values, ethical issues, and the meaning of work, as vital to the experience of job engagement.

In addressing research question 2: 'What is the role of job engagement in community nurse burnout?' I explored whether job engagement may contribute to exhaustion and burnout and

not only health and well-being, and the processes that might inhibit job engagement among community nurses (presented in paper 2). Nine of the nurses had experienced stress bringing them close to burnout, and one of them to burnout, yet they had all regained enthusiastic engagement in nursing at the time of the interviews. Their stories revealed a negative process, in which job engagement played a perverse role which brought them to the brink of burnout. Choosing nursing as a profession helped the nurses to respond to an existential issue: finding meaning in life. The nurses expressed that a sense of calling was an underlying guide to their choice of profession. The need to experience and hold on to meaning tended to overshadow the importance of manageability of one's professional responsibilities. High job engagement, which followed from the nurses' sense of calling to the nursing profession and the nurses' devotion to work, contributed to a strong sense of duty and heavy self-demand regarding own and other's levels of performance. This got them into trouble. The study illustrated that moral distress and overload leading to near burnout may be exacerbated by a high level of job engagement and frustration about not living up to one's high ethical standards. Thus, job engagement appears to play a paradoxical role in nurse burnout. Further, the study also suggests that job engagement may not only promote thriving on the job, but may also contribute to a negative process leading to poor functioning. The motivational factor of this negative process also appeared to be the sense of calling and the calling/vocation match, where highly diligent dutifulness resulted in experiences of moral distress, overload, fatigue and even burnout.

In addressing research question 3: 'How do thriving nurses maintain and enhance their job engagement?, I explored the role of self-care in maintaining and enhancing job engagement among thriving community nurses, and I aimed at summarising the salutogenic and pathogenic processes in which job engagement plays a central role (presented in paper 3). In nine cases, the perceived failure to live up to one's own performance demands contributed to the process of burning out. This triggered introspection, sensibility and reflection, leading to coping, avoidance of burnout, and the enhancement of job engagement. The nurses showed alertness, appraisal and the ability to act to preserve job engagement. This pattern brought to mind the construct 'sensibility' which is theorized in paper 3 and argued to be of vital importance to maintain and enhance job engagement. To enhance job engagement, the nurses worked to lower the too-rigorous standards they had set for themselves and for others, and/or they changed jobs or modified their working conditions. This self-care happened on a philosophical level and on a practical level and often combined actions played out in the

following way: the nurses' abiding existential curiosity about the surrounding world and about self, stimulated self-monitoring and self-tuning in their search for coherence. 'Existential curiosity' and 'monitoring and self-tuning' were thus the forerunners to action. The data revealed six main active coping strategies which provided the direct means to regain job engagement; 'striving to be a realistic idealist'; 'engaging in meaningful activities alongside nursing'; 'ensuring a place for silence and withdrawn peace'; 'solving emotional problems'; 'learning from experience' and;' ability and willingness to undertake major change'. The 'Self-tuning Model of Self-care' was developed to summarise these processes graphically. The Model shows three parallel processes, one of which is characterised as salutogenic and another as pathogenic, both driven by the same motivational factor—a sense of calling and the calling/vocation match. These two processes are mediated by a third process involving introspection, sensibility, reflection and active coping. This is a sensing/reacting process that is adaptive in that it can result in changes leading to regaining job engagement. Thus, the promotion and maintaining of job engagement appears to be dependent on the nurses' self-care.

Conclusion: Job engagement plays a seemingly paradoxical role in nurse work-life. A nurse's sense of calling and his/her experience of calling/vocation match stimulate two processes leading simultaneously to high job engagement and to highly diligent dutifulness. The salutogenic process, in which job engagement plays a central role, can be stimulated, and meaning, zest for work and vitality can be protected if the nurse engages in an ongoing mediating self-care process described in this study as 'self-tuning'. This self-care process is teachable and has as its fundament the talent and habits of introspection, sensibility, reflection and active coping. Self-tuning also depends on the willingness to learn from experience and on being able to take action to improve one's situation. The findings of this study, informed by the experience of nurses, may have relevance to persons in stressful professions who wish to stimulate their job engagement or who find themselves on the path to burnout.

1 INTRODUCTION

1.1 Focus and purpose of the study – research problem

This dissertation is about how and why community nurses can thrive despite the burdens of nursing. I wanted to study nurses who were engaged in their job and who experienced a high quality work-life. My idea was that if we could better understand their job engagement, we might be able to suggest ways to help all community nurses to thrive. I wished to address the question 'how and why do nurses in community health care experience job engagement and stay healthy – and what can we learn from those who succeed'.

To understand processes of job engagement and burnout resistance in the context of community nursing, research is needed in community nursing settings. There is inadequacy in the current body of knowledge concerning nursing burnout, which has two aspects. First, community nursing studies have been undertaken mostly in mental health settings (Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000), not the generalist settings of interest in this study. Second, the research has tended to address the risk factors that lead to burnout (Gillespie & Melby, 2003; Hummelvoll & Severinsson, 2001; Severinsson, 2003; Sundin-Huard & Fahy, 1999), rather than the protective factors promoting job engagement and helping one to resist burnout. This study aims to fill this gap, by seeking understanding of resistance processes as reported by a select group of community nurses, who were selected because they were reputed to thrive despite the adversities of nursing at the community level.

1.2 The adversity of community nursing

Community health nurses work in public health clinics, home nursing care and nursing homes. Public health nurses work primarily with families with infants, small children and adolescents. In home nursing care and nursing homes people over 80 represent the main group of patients. These are mostly women with severe and complex health problems, most of whom live in nursing homes. During the last decade, the patient group below the age of 67 years has expanded the most. Thirty-nine percent of this group suffers from a variety of somatic illnesses such as multiple sclerosis, apoplexy, and head- and back injuries. Most

patients under 67 years of age receive home nursing care (Stortingsmelding, 2006). Cost-cutting efforts across the health care system have redirected some patients from hospitals and rehabilitation centres, to community-based care. Therefore, nurses working in home care and in nursing homes provide care for patients with increasingly complex health problems which were previously managed in hospitals or rehabilitation facilities. Thus, there is a general tendency to extract more services with less expenditure, resulting in fewer nurses working harder to manage the same or even increasing work loads (Vike, 2003). As a result of this, community nursing in Norway is increasingly stressful.

Although there are no reliable national statistics available of the number of nurses leaving the community health sector in Norway due to burnout or premature retirement, the level of sick leave is increasing and was 9 percent at the end of 2005. This is higher than in other professions. The Norwegian government estimates the need for more than 3,000 full-time nurses in the community health sector by 2009, and considers the problem severe enough to enact programmes to alter working conditions in an effort to retain nurses at risk of disability or premature retirement (Stortingsmelding, 2006).

While research on burnout is increasing, relatively little attention is given to research on how to stimulate job engagement and enthusiasm (Maslach, 2003; Maslach, Schaufeli, & Leiter, 2001; Richardsen, 2002; Schaufeli, Salanova, Gonzàles-Romà, & Bakker, 2001). Importantly, there are many examples of nurses who thrive despite difficult and strenuous working conditions. A premise of this dissertation is that there is potentially much to be learned from such persons that can help us to understand the opposite of burnout — job engagement. Understanding the phenomenon of job engagement in the face of adversity in nursing is imperative in order to illuminate strategies that might prevent nurses from languishing or burning out.

1.3 Work place health promotion

Based on the importance of the work place as an arena for public health, the European Union (EU) has established a European Network for Workplace Health Promotion. In the Network's declaration it is stated that a health promoting workplace can be achieved by a combination of: 1) improvements in work organizations and working environments, 2) stimulating employees' cooperation 3) and encouraging individual and personal development (WHO,

1998). Thus, expected outcomes of healthy persons in healthy organizations are tied to involvement of all employees and efforts on individual-, organisational- and community and societal levels. At present there is a gap between the goal of healthy persons in healthy organizations and knowledge of how this can be achieved, and efforts to identify examples of health promoting work life practices are encouraged (WHO, 1998). However, most workplace health research does not emphasise the importance of protective factors for health, preferring instead to take a risk factor approach (Bergan & Fisher, 2003; Killien, 2004).

Interest in protective factors is nevertheless growing, stimulated by the concept of the work place as an environment that can actually promote workers' health (Polanyi, Frank, Shannon, Sullivan, & Lavis, 2000), by developing the strength of individuals and their capacity to cope with the challenges of daily life (Seligman & Csikszentmihalyi, 2000). The present study was undertaken from this health promotion perspective, aiming at exploring protective factors from an individual perspective, and thus setting a temporary parenthesis around the organizational and societal levels. The equal importance of these levels in health promotion work is not meant to be diminished by the focus at the level of the individual.

2 THEORETICAL PERSPECTIVES

In accordance with a phenomenological hermeneutical research tradition (see the method section) the study moves between the ideal of phenomenological openness and hermeneutical reflective interpretation (Alvesson & Sköldberg, 2005). This implies that data collection, analysis, review of research and theories, the forming of new assumptions and the jeopardising of them in collecting further data—in short, the moving between empirical data and theory—are parallel processes. At some point in the process the researcher finishes data collection and settles for an interesting and appropriate theoretical perspective from which to view the data. To present this process in a reader-friendly fashion here, means presenting theoretical perspectives that were not fully present in my mind when I commenced the project. They have to a large degree, consistent with the chosen methodological design, grown out of the hermeneutical, spiral-like movement.

2.1 Salutogenesis

Wanting to study job engagement and work-life well-being from a health promotion perspective, I searched for a suitable theoretical frame of reference. This led me to the salutogenic perspective of the late Professor Aron Antonovsky (1979; 1987; 2000). The salutogenic perspective is considered to be an important theoretical framework for health promotion as it focuses on problem solving/finding solutions; it identifies General Resistance Resources (GRR) that can help people move in the direction of positive health, and it also identifies a global and pervasive sense in individuals (and in groups, populations and systems) that serve as the overall mechanism or capacity for moving towards health, known as the Sense of Coherence (SOC) (Lindström & Eriksson, 2006).

Antonovsky posed the question of the origins of health (*salutogenesis*), in comparison to the question of the origins of disease (*pathogenesis*) (Antonovsky, 2000, 12 my translation): "How do we manage to stay healthy?" and "Why do people find themselves in the positive end of the good health—bad health continuum?" These questions seem to capture the tone of departure of this study. Antonovsky (1979) noted that stressors are omnipresent in human existence, and that throughout our lives stressors continuously put us into a state of tension

and that it thus must be fruitful to study successful tension management and coping. Further, Antonovsky (1979; 1987) proposed two key salutogenic constructs, the General Resistance Resources (GRR) and the Sense of Coherence (SOC). The GRR are biological, psychosocial and material factors (e.g. money, knowledge, experience, self-esteem, commitment, social support, healthy behaviour, view of life) that help people perceive their lives as consistent, structured and understandable (Lindström & Eriksson, 2006). Over time, a person with many such experiences comes to see the world as one that makes sense. Antonovsky (1979; 1987) developed the construct of SOC as he tried to explain the common traits of all General Resistance Resources and the processes that link these resources to health. Sense of Coherence is understood to be a global disposition of seeing the world as comprehensible, manageable and meaningful, respectively the cognitive, behavioural and motivational components of SOC. The SOC is thus ones ability to make use of the GRR and to perceive that one can successfully manage life and its ever present stressors and challenges (Lindström & Eriksson, 2006). Important also from this perspective is Antonovsky's (1987) concept of boundaries. He argues that not all stimuli need to be perceived as coherent, only those that one defines as important in one's life. Always included, however, are one's inner feelings, one's immediate interpersonal relations, one's major activity such as work and one's existential issues.

Nurses are often unable to change the basic conditions of their work life, yet many manage to extract meaning and satisfaction from their work and to cope with stress in ways that lead to fulfilment on the job and in their private life. Employing a salutogenic perspective to study nurses who thrive despite the hardships of community health care is, therefore, useful and in accordance with the purpose of the study.

2.2 Self-care and coping

The self-care construct is the focus of paper 3. 'Coping' is suggested as a subordinate concept to self-care in 'The Self-tuning Model of Self-care', and therefore some theoretical perspectives related to coping are presented below. Coping, as the term is used here, distinguishes cognitions and behaviours that are invoked as an adaptive response to stressful life experiences (Eckenrode, 1991). The term coping resources refers both to intrapersonal characteristics (e.g., hardiness, sense of coherence, self-efficacy, spirituality) and to environmental resources (e.g., social support, material comforts, protective interventions from

others) that may be mobilised when stressors reach, or threaten to reach, distressful levels. Antonovsky (1979) terms these 'resistance resources'. Depending on one's situation, the combination of resistance resources available and one's experience and skill in mounting resistance to stress, may lead to a wide range of resistance responses to stress. The range of possible responses has been summarised in Perlin and Schooler's (1978) classic trilogy: alter the problem directly; change one's way of viewing the problem; manage emotional distress aroused by the problem. When chronic, rather than acute stress is considered, resistance may well involve a combination of strategies, resulting over a period of time in varying degrees of satisfactory outcomes. Resistance may thus be considered a process rather than an event, and many models of resistance processes have been offered. Lazarus and Folkman (1984) have made a critical contribution to this arena, by pointing out that resistance—or coping as they term it—is affected more by how a person perceives his or her environment, than by its objective features. Thus, stress is, in an important sense, personally and socially constructed. This helps to explain seemingly paradoxical outcomes for two nurses working in the same demanding environment and who have similar responsibilities: one burning out, and the other resisting—thriving even—despite adversity.

2.3 Pathogenesis

In starting this work I assumed that job engagement is health promoting. One of the main findings is, however, that job engagement has a paradoxical role in nurse burnout—a pathogenic-like process was revealed in the analyses. The study's theoretical perspectives on health and pathogenesis will therefore be presented here.

Pathogenesis is the mechanism(s) by which disease progresses. In pathogenic orientations, such as the biomedical paradigm, disease is seen to be caused by mono-causal factors such as bacteria, or by intertwined and more complex microbiological, psychosocial, and chemical elements. Examples of theories of pathogenesis include: 1) type A- behaviour heightens the risk of heart disease, 2) learnt helplessness contributes to the development of depression, and, 3) internalising hostility may contribute to the development of cancer. Stress may be considered as pathogenic and disease-producing, or as a risk factor that one at best may limit, or take necessary precautions against, or alleviate through different buffers. Antonovsky (2000), however, questions the assumption that all stress is pathogenic, and was concerned that the almost total domination of the pathogenic paradigm would limit further research and

knowledge development (Antonovsky, 2000). Arlow (1981) points out that when the term pathogenesis is used, what is usually referred to is a theory of pathogenesis, not a confirmed mechanism. The difference between a theory of pathogenesis and pathogenesis is important. Arlow (1981) argues that shared theories of pathogenesis can lead to the widespread use of treatments that are ineffective, or even harmful, when the actual pathogenic mechanism is different to the prevailing theory of pathogenesis.

This study suggests that one of the processes revealed in the analysis of the data is pathogenic. The pathogenic construct is, however, not applied in the sense of the traditional pathogenic paradigm that was contested by Antonovsky (2000). Rather, the term is used in this study as described in the holistic health paradigm, presented below. The findings suggest a *theory* of pathogenesis and not a confirmed mechanism.

2.4 Holistic perspective on health

The symptoms of burnout are not specific to the body, mind, or emotions, or to social relationships. Experiencing burnout influences all aspects of being, including also one's existential dimension. Thus, in studying nurses' job engagement and burnout resistance, a holistic perspective on health is needed.

There is an ongoing debate of how the concept of health is best defined and understood. In 1948 the World Health Organisation (WHO) defined health as: "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity"(WHO, 1948). By this definition, WHO provided a positive concept of health as something more than the opposite of disease. Health, well-being and illness are considered subjective experiences. In applying a holistic perspective in this study, the existential/spiritual dimension is made even more explicit than in the WHO definition. Man is understood as a biological-, cultural- and social being with psychological and existential/spiritual dimensions, and health is a complex phenomenon with physical, psychological and socio-cultural and spiritual dimensions that can not be considered independently of each other (Karoliussen, 2002). Hence, the mere absence of physical and psychological disease does not in itself constitute adequate conditions for good health, and a person may very well experience well-being despite the existence of pathogenic processes and objective signs of disease (Eriksson, 1989). Although the importance of pathogenesis is underlined in the above perspective, a person's

subjective experience of well-being and health is considered to carry the most weight. From this perspective, it may follow that a person in excellent physical condition who is imprisoned has poor health.

3 JOB ENGAGEMENT

Discussions of job engagement, burnout, and nurses and burnout are presented in the papers. Here, I will talk in short about *job engagement*, and I will present the concepts of *calling, zest for work* and *vitality* in detail, as they were addressed only briefly in paper 1. The concepts *calling, zest for work* and *vitality* are translations of the Norwegian expressions *'kall', 'arbeidsglede'* and *'vitalitet/livskraft'* respectively.

3.1 Job engagement

In opposition to traditional burnout research, some researchers have, in recent years, increased their focus on how to strengthen positive resources to stimulate energy and enthusiasm at work (Maslach & Goldberg, 1998; Maslach & Leiter, 1997; Maslach, Schaufeli, & Leiter, 2001; Schaufeli, Salanova, Gonzàles-Romà, & Bakker, 2001). For example, Maslach and Leiter (1997) defined burnout as the gradual erosion of job engagement, instead of focusing on the exhaustion of energy and resources. Through a gradual process of increasing mismatch between a person and his or her job, energy turns to exhaustion, engagement to cynicism, and efficacy to inefficacy. Job engagement is therefore defined as the positive opposite of burnout, and is characterized by energy, involvement and efficacy (Maslach, 2003; Maslach & Leiter, 1997). A theoretical analysis of work-related well-being identified two underlying dimensions:1) activation; ranging from exhaustion to vigour, and 2) identification; ranging from cynicism to dedication (Schaufeli, Salanova, Gonzàles-Romà, & Bakker, 2001). In this analysis, burnout is characterised by a combination of exhaustion (low activation) and cynicism (low identification), whereas engagement is characterised by a combination of vigour (high activation) and dedication (high identification). Based on this theoretical analysis and also on in-depth interviews with engaged employees, job engagement was defined somewhat differently by Schaufeli and colleagues (2001, 74) as a:

> *"positive, fulfilling, work-related state of mind that is characterized by vigor, dedication and absorption…it refers to a persistent and pervasive affective-cognitive state that is not focused on any particular object, event, individual or behaviour…*Vigor *is characterized by high levels of energy and mental resilience*

while working, the willingness to invest effort in one's work, and persistence even in the face of difficulties. Dedication *is characterized by a sense of significance, enthusiasm, inspiration, pride and challenge.* Absorption *is characterized by being fully concentrated and deeply engrossed in one's work, whereby time passes quickly and one has difficulties with detaching oneself from work."*

The term 'absorption' is a positive element in this definition. In contrast, Hallsten (1993) introduces the term 'absorbing commitment' to refer to a particular kind of vulnerability, wherein work is the only role one has that gives a sense of self-worth, and the actual phase of burning out comes when the concordance between the goals of the organisation and the person somehow diminishes. The self-defining role—I am my performance at work—is threatened, and there is no alternative role (Hallsten, 1993).

3.2 Calling

'Calling' is a term with deep religious roots and associations. Calling or vocation were originally concepts used to describe a call away from the world of productive activity in order to dedicate one's life to prayer and contemplation (Dawson, 2005). In the Concise Oxford English Dictionary (2006), calling is defined as: *"a strong urge towards a particular way of life or career; a vocation - a profession or occupation",* while vocation is defined as: *1. a strong feeling of suitability for a particular career or occupation. 2. a person's employment or main occupation, especially one requiring dedication • a trade or profession - from vocare 'to call'* . In early Greek and Roman times, work was considered more as an unavoidable toil than as a valuable activity in its own right or as a source of personal satisfaction or material gain (Applebaum, 1992; Arendt, 1958). The tendency to hold contemplation in higher social regard than practical work persisted by and large into the medieval period. However, during the Protestant Reformation of the late 15th and early 16th centuries, this view of work underwent important changes (Applebaum, 1992; Arendt, 1958; Martinsen, 2001). The German theologian, Martin Luther (1483-1546), is regarded as being central in this shift (Dawson, 2005; Martinsen, 2001).

In modern nursing, calling is understood and used in at least three different ways (Martinsen, 2001, 87): 1) as an act of faith—as Christian faith expressed through a loving disposition made active through a person's actions, 2) as religious and human—calling is a worldly task

given from God to take care of needy and destitute persons, 3) and as a claim life itself puts on us to meet and take care of our fellow human beings—the call is given as a law of life about charity as something essentially and fundamentally human. Moving away from the realm of nursing, Dawson points out that in the 20th century the meaning of vocation has also (Dawson, 2005, 226): *"come to reflect a quest for personal meaning and singular life purpose."* From this perspective it seems that our deepest calling has to do with personal identity and with the optimal expression of inherent potential. 'Growing into authentic selfhood', seems to be an important part of calling and finding meaningful work (Palmer, 2000). This idea is, however, criticized by Baumann (2005), who argues that work as vocation and the meaning of life is the privilege of the few, the elite, whilst the majority too often hold meaningless jobs with little opportunity for fulfilment. Further, he argues that the only vocation available to everybody is the vocation of the consumer. He is critical of the tendencies of the members of modern societies to become a part of an endless cycle of working and spending, seeking fulfilment not through work, but through the fruits of work (Baumann, 2005). In his analysis of modernity, Taylor (2003) raises authenticity as an important contemporary moral ideal. The moral ideal behind the pursuit of self-actualisation is to be true to oneself, however not in a self-centered fashion. Taylor's point is that there is a moral strength inherent in self-actualization and that many feel called to this endeavour (Taylor, 2003). This notion resembles the idea that calling is a claim life itself puts on us to take care of our fellow human beings, and that optimal fulfilling and expression of one's potential is the way to listen and attend to this calling.

The concepts of calling and vocation are also of interest in literature and research on leadership (Sangeeta, 2006), holistic health (Ventegodt, Kandel, & Merrick, 2005), and vocational guidance (Whitworth, Kimsey-House, Kimsey-House, & Sandahl, 2007). Cochran (1990) uses the term "sense of vocation", Sangeeta (2006) the phrase "higher purpose", Whitworth and colleagues (2007) writes about the related concept of "urge" and Ventegodt and colleagues (2005) use the term "purpose in life".

What is interesting in the literature on holistic health, is that the notion of following one's calling, or purpose in life, may be energy-giving and tied to health promoting benefits of the person following the call, and that it may even be an act of protection and the promotion of life itself (Ventegodt, Andersen, & Merrick, 2003a ; Ventegodt, Kandel, & Merrick, 2005).

Ventegodt and colleagues argue that all humans have a natural predilection for using their knowledge and themselves to create value. However, creating in the absence of feeling called to one's endeavours may result in burnout (Ventegodt, Merrick, & Andersen, 2003b , 1054).

One may expect that being called to nursing in the beginning of the twentieth century in largely secular Norway is more tied to the ideals and values of the profession, or to calling as a law of life about charity and as a claim life itself puts forward to meet and take care of fellow human beings, than to the traditionally more religious flavours of the concept. How this may have influenced the research reported here is taken up in the Discussion.

3.3 Zest for work

Zest for work is one of the most valued personal assets entrusted a human being. Interestingly, it is difficult to find research on the "arbeidsglede" or "zest for work" theme. Internet searches give many results, but limited to research, the Internet is less helpful. One will, however, find aspects referring to, or relevant to, zest for work when searching for related concepts such as 'health and well-being at work' and 'job satisfaction'; see for example a review by (Sørensen, Rapmund, Fuglerud, Hilsen, & Grimsmo, 1998). While this body of research is extensive, it takes mostly a risk factor approach, and thus falls outside the scope of this study. The history of work-life shows that since the end of the 18th century the primary focus has been on the reduction of the human costs of work. Zest for work has been seldom addressed (Halvorsen, 2002).

The Norwegian word, "glede", can be translated into the English words "joy", "delight", "pleasure", "satisfaction" and "happiness", whereas "arbeidets glede" can be translated into "the pleasure of work", "the satisfaction of work" and "arbeidsglede" into "job satisfaction" and "enthusiasm for one's work" ("www.ordnett.no"). However, in order to capture also the dimensions of power, enthusiasm and eagerness that arose from my thesis, the phrase "zest for work" was chosen. "Zest" is defined as: great enthusiasm and energy. • excitement or piquancy.("The Concise Oxford English Dictionary, Eleventh edition revised ", 2006) and it seems to more fully represent the idea of "arbeidsglede" that I wished to capture. Thus, "zest for work", as it is used in this study, is synonymous with the Norwegian word "arbeidsglede".

In the Nordic countries, zest for work is considered to be a natural resource like water, oil and lumber—it is regarded as an inner factor, an uplifting experience, a feeling of mastering and managing one's work (Sørensen, 2003). Spilling (1955) discusses the importance of zest for work in defining Norway's self-understanding as a young nation in the beginning of the 19th century, and argues that zest for work lies first and foremost in the intrinsic value of the work itself, and that what is produced has value beyond that of material gain. This is in accordance with the definition of job engagement presented above, having to do with enthusiasm for the work itself. From a philosophical point of view, Spilling (1955) argues further that work can be divided into three categories: a job, a profession and a calling. A job is something one does, and has to do, to exist. In a profession, one may find zest for work expressed as joy and professional pride. However, in the calling, work transcends the interests of the person and it is lifted to a platform of service where zest for work has the very best of conditions. Spilling's (1955) concern was that we must not sacrifice zest for work on the altar of ever increasing demands for higher wages and better working conditions.

In an analysis of zest for work among 1000 employees and 575 leaders in different Norwegian organisations, 72 % of respondents said that they always looked forward to going to work (Børtnes, 2003). Those in the age range of 50 – 59 years, and those with higher education were the ones who most often answered that they looked forward to going to work. In general, the oldest workers were the ones happiest with their work. Of all the employees in the study, 87% claimed that their working environment was the single most important factor accounting for their zest for work – while 57% of the leaders felt the same. In addition, factors such as having a job one enjoys and manages, pleasing cooperation with leaders and co-workers, skilful leaders, being seen and taken seriously, and open and good communication between leaders and employees were pointed out as important for zest for work (Børtnes, 2003). Only 8% of the employees and none of the leaders claimed that wages were important for their zest for work.

Although presented in a popular scientific fashion, the work of Velten (2003) is an interesting presentation of 15 years of systematic investigations on practices of leadership, employee satisfaction and zest for work in about 30 Nordic organizations. Velten (2003) found a positive correlation between good leadership and zest for work, and also between zest for work and perceived possibilities to be active and engaged, to take responsibility, to use one's competence, to grow and develop and to be respected and appreciated. A positive correlation

was also found between zest for work and useful initiatives taken towards underperformers and employees with poor results (Velten, 2003).

These findings indicate that zest for work is still considered to have value other than that of material gain. It is the work itself that is important, as well as the experience of being good at what one does, being able to learn and develop, and enjoying good relationships with colleagues and with leaders.

3.4 Vitality

The Norwegian word 'vitalitet' is described as 'livskraft, liv, energi, livsdyktighet, leveevne' and it is translated into the English words 'vitality, vigour, energy, spirit' ("www.ordnett.no"). The meta-concept 'vitality' is derived from '*vita'*, or 'life', and it refers generally to aliveness and positive energy that project from a vital person to others. Vitality has in fact many meanings, and the terms 'cognitive vitality', 'intellectual vitality', 'physical vitality' (amongst others) illustrate the futility of attempting too much precision in the meta-construct. The term is used here in the psychological sense of Monsen (1991, 150):

> *"...vitality is a combination of impulsiveness and reflection: vitality is a good reciprocal relationship between how a person feels emotionally and what he does with his emotions experientially and expressively..."*

Menckel and Österblom (2000) identify three key concepts related to health promoting processes in an organization: 'leadership', 'resources' and 'own power and strength', the latter of which is considered the most important. In their view, it is paramount for health promotion that people invest their own power and strength, that they mobilise their resources and that they are offered the opportunity to participate, and dare to be engaged and to start new initiatives. They agree that some learning organizations seem to be health promoting, but that merely creating a learning organization is not sufficient to promote health. The overarching goal must be to create a healthy organization. They claim that a healthy organization is probably a learning organization, but that a learning organization is not necessarily healthy (Menckel & Österholm, 2000). Their perspectives on power and strength are interesting and are closely akin to the concept of

vitality as it is meant in this study. Vitality refers to feelings of vigour, strong life energy and the will to exert oneself.

3.5 Summery of aims and research questions of the study

The main objective of this study was to explore in-depth the characteristics of job engagement among thriving, community health nurses, and to investigate how job engagement can be maintained and promoted. This was done in order to expand and to nuance current knowledge of workplace health promotion, and of how nurse burnout and premature retirement can be prevented. The assumption that job engagement is health promoting was explicit from the start. Job engagement was considered to consist of three basic elements, "calling", "zest for work" and "vitality", that needed to be explored in depth. *Vitality* was defined by feelings of vigour, strong life energy, and the will to exert oneself. *Zest for work* was defined by feelings of vocation-related joy, happiness, enthusiasm, and dedication. *Calling* was defined by feelings of having a mission or purpose, including commitment to and healthy absorption in one's vocation and having the feeling of being in the right place and in the right position. The following research questions and aims guided the research presented in this study.

Research question 1: How do thriving nurses experience job engagement?
Aim 1 was to explore the phenomena, job engagement, among community nurses who were thriving at the time they participated in the study.
Aim 2 was to explore the processes that promote job engagement among community nurses.
The findings are presented in paper 1.

Research question 2: What is the role of job engagement in community nurse burnout?
Aim 3 was to explore whether job engagement may contribute to exhaustion and burnout and not only to health and well-being.
Aim 4 was to explore the processes that might inhibit job engagement among community nurses.
The findings are presented in paper 2.

Research question 3: How do thriving nurses maintain and enhance their job engagement?
Aim 5 was to explore the role of self-care in maintaining and enhancing job engagement among thriving community nurses.

Aim 6 was to summarise the positive and negative processes in which job engagement plays a central role.

The findings are presented in paper 3, which draws also on the findings presented in papers 1 and 2.

4 METHOD – FROM SCIENTIFIC POSITION TO CHOICE OF METHOD

One empirical in-depth interview study and qualitative content analysis were conducted to address the questions and aims, using an explorative qualitative design (Denzin & Lincoln, 2000). The methodology is presented in detail, following brief treatment below, of how I came to my choice of methodology.

All empirical research in health science, as in science in general, is based on assumptions about the phenomena and the reality the researcher is interested in. There are ontological and epistemological assumptions built into the research. These premises need to be explicit. If they are not, the research is not available for critical examination, which is necessary for development of scientific knowledge (Tranøy, 1986). Due to the different views of scientists on the position of models of man in the philosophy of science and scientific theory, discussions on models of man and ontology are often ambiguous and vague (Nortvedt & Grimen, 2004). Models of man will, however, always play its conscious or unconscious part in research and discussions heron, which may influence and form the choices taken by a person in daily living as it may in research and scientific endeavours. To ensure a research design based on inner consistency, the researcher needs, as completely as possible, to have clarified ideas of his/her ontological foundation. Without this inner logic, inconsistencies may arise between ontological position and choice of data collection methods and analysis, and subsequently inconsistencies in the researcher's argumentations (Alvesson & Sköldberg, 2005; Hauge, 2004)

4.1 Ontological position

In nursing science one traditionally claims to have a humanistic and holistic view of man, the meaning of which is, however, usually vaguely described (Nortvedt & Grimen, 2004). This study is grounded in the humanistic and holistic position, in which a human being is understood as a biological, cultural and social being with psychological and existential/spiritual dimensions. A human being is, thus, a unity of body, soul and spirit, which is in constant interaction with its environment. The whole of the human is different from, and more than, the sum of its parts. The humanistic approach involves a belief in human

beings' capacity to make new and better choices to improve own situation. It involves a belief in human beings' capability to take responsibility for own life, and it involves a belief in a collectivistic concept of man, meaning that we all, on a deep level, concern one another. The life of a human being is always linked to other human beings' lives in an open world we can not see the beginning of, or the end to (Kristoffersen, 2006). A consequence of these ideas is that a human being is folded into life, which is dynamic and always changing. Moreover, the human being is relating to life and environment through its senses, and is always present in a tuned way. This participatory awareness brings forth a moral dimension and the awareness of the value of protecting all life surrounding us (Kristoffersen, 2006).

Based on these considerations, a human being is, in this study, considered a unity of body, soul and spirit in changing movement and constant interactions with his or her environment. He or she searches for meaning, and is present in life in a perceiving, interpretive and tuned way, and has the potential for improving and taking responsibility for his or her own life situation. For this ontological stand to be something more than theoretical, it must be demonstrated and 'lived' in the encounters with the nurses participating in the study, and in the handling of the empirical material gathered. It implies that I select a methodology that allows the nurses to present themselves as 'whole' persons, giving them the necessary time and space to do so.

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4.1.1 Phenomenology, hermeneutics and epistemological consequences

Phenomenology is an influential philosophy in nursing science which has given birth to various methodological approaches with the aim of studying and understanding man and his complex reality. In the present study phenomenology is considered a type of philosophical understanding, providing an empirical research approach that encompasses the research process from the start to the end. In this section, I will present relevant passages of Husserl's (1998) and Heidegger's (2006/1962) phenomenology. Presentations and elaborations by Bengtsson (1999; 2006b), Zahavi (1999) and Østergaard (1998) have also inspired the study. These considerations will lead to hermeneutics, and some relevant ideas presented by Gadamer (1993/1960) which constitute the basic methodological foundation of the study.

Despite differences in phenomenological understandings, the phenomenological movement come together on at least two basic ideas, or constants, which is also the phenomenological

attitude and approach applied in the present study (Bengtsson, 1999, 11): a) *'to turn to the things themselves'*, and b) *'a sensitivity and fidelity towards the things themselves'*. The word 'phenomenon' is Greek and it means: *"that which shows itself"* and the word is used in this sense in phenomenology (Bengtsson, 1999, 11). This presupposes that there is someone who sees and perceives. The concept thus implies interdependence between object and subject. 'Turning to the things themselves', therefore, implies turning towards a subject, as the things always are things to someone and never things in their own right. In this study, it means to turn to the nurses who experience job engagement at the moment of the interviews, and to try to seize their experiences and reflections heron.

Moreover, Husserl (1998) argued that it is important to reflect upon worldly experiences directly to attain neutral descriptions of them. In presenting the concept of 'the life-world' Husserl rejects the differentiation, given by the natural sciences, between the objective world as it is in itself, and the subjective world, such as it presents itself to the individual person (Zahavi, 1999). He argues that the life-world is the daily experienced reality in which we live our lives, a world we mostly take for granted. The life-world is pre-scientific and pre-reflective, meaning that we are 'always already' present in a world which is always there, and that we cannot escape (Bengtsson, 2006a). The life-world is present as an implicit background.

In order to attain neutral descriptions, Husserl (1998, Introduction, XVIII) claims that everything experienced finds its "*essential grounds*" in a pure or transcendental consciousness. The idea is that 'the things themselves' must be allowed to be expressed, unbiased and without prejudice, before meanings and theories are formed and before interpretations have been made (Østergaard, 1998). There follows from this a need to bracket theories and preconceptions, and Husserl develops a particular method for this exercise, the Epochèen, the purpose of which was to hold back every judgement of existence, and thus to separate existence and essence (Bengtsson, 2006a).

Heidegger (2006/1962) did not agree with Husserl that it is possible to attain neutral descriptions and to separate essence from existence. In his philosophy Heidegger (2006/1962) replaces Husserl's concepts of 'I' and 'consciousness' with 'Dasein' (Being) which refers to the subject who lives in the world. The subject is always concretely situated in the world and tuned by it. The subject is an actor, not a spectator, and in its most inner existence Dasein is

social, and is therefore able to understand others. Heidegger, thus, dissolves the separation between subject-object. Dasein cannot be objectified, it has to be experienced. To be tuned towards Dasein (Being) and reveal it, it follows that the person must already have an understanding, a pre-understanding, of this Being (Østergaard, 1998). The world is the wholeness in which the things appear and are given meaning. The person is already thrown into the world, existing in it and to it, socially and historically. Everyone is a participator in a common world.

This will imply that when I reflect on myself as a researcher conducting this study, or on the collected stories of the nurses, these acts occur in the world and not in an independent, objective position outside the world. In sharing a common world it will always be possible to understand parts of another person's life-world, called inter-subjectivity (Bengtsson, 1999). It means that it is possible for me to grasp the meaning of the nurses' stories, but due to the historicity [1]of our life-worlds', the nurses' life-worlds can also appear unfamiliar and be difficult to understand.

In his writings, Heidegger turns away from Husserl's transcendental phenomenology and towards hermeneutics. Heidegger's concepts of 'pre-understanding', 'Being' and 'the world' radicalize hermeneutics, as does Gadamer's interpretation of the hermeneutical circle (Østergaard, 1998). According to Heidegger and Gadamer, the researcher's understanding becomes a dependent part of the hermeneutic circle. Thus, in wanting to understand the transcribed texts representing the nurses' stories, I am unable to view them independently of my own pre-understanding. However, part of the researcher's pre-understanding is an explicit willingness to accept that the text may have something true to convey (Gadamer, 1993/1960). This is a premise I will need to acknowledge in order to be able to understand the texts. The hermeneutical circle thus becomes an image of the reciprocal relationship between that which the transcribed texts of the nurses' stories say and the interpretations I make based on my pre-understanding.

Gadamer (1993/1960) also introduced the concept of 'horizon' which is relevant in this study. 'Horizon' is used as a metaphor for a person's mental field of sight. 'Horizon' is created by the life we lead, by our experiences and by the history and tradition lying behind us. It can

[1] '*Historicity*' means that every interpretation is mediated by traditions, and consists of the three aspects of time: past, present and future as indissoluble moments (Alvesson & Sköldberg, 2005, 85).

never be transcended, although when taking an open and questioning attitude towards the world one's horizon may be moved and extended (Gadamer, 1993/1960). An open and questioning attitude makes is possible to gain access to, and understand phenomena in another person's life-world, and this may result in a movement of one's horizon. As described in later sections, having an open and questioning attitude led me to be self-reflective when considering the factors that would enable me to be open and questioning in an optimal way, or that may hinder me in this endeavour.

From the above presentation, it follows that the world is complex, ambiguous and ambivalent. The world is complex because one has to try to understand a phenomenon within the context in which it exists. In order to gain insight into a nurses' experience of job engagement and self-care, I need to study it as the experience is lived and passed on to me through each nurse's story and their subsequent reflections. This means that I will need to try to search for meaning within complex and context-dependent situations. Further, the world is ambiguous and ambivalent due to cultural and historical differences. This may, for example, lead me to understand a situation and a phenomenon differently than the nurses do because our horizons of understanding are different.

In conclusion, the theoretical position presented above is an ontological and epistemological standpoint that draws on the following phenomenological and hermeneutical principles:

a) a turn towards the things themselves
b) a sensitivity and faithfulness towards the things themselves
c) a sincere consideration of own pre-understanding
d) knowledge is dependent on the context in which it has come forth; thus knowledge is limited
e) the world is complex and one can always extend one's horizon of understanding; thus, knowledge is changing
f) truth is focusing on meaning, the revealing of deeper meaning, and is tied to inter-subjectivity

4.1.2 The hermeneutical spiral

This study is characterised by being both orientated towards description of empirical material, and by having an interpretive focus. The movement between empiricism and interpretive lines of thought is typical for a hermeneutical research process (Alvesson & Sköldberg, 2005). This study was not purely inductive at the outset, as the choices that I made at the beginning of the study have guided the research process. Nor was it purely deductive, as the phenomenological ideal of openness was also present. A hermeneutical process is often referred to as a hermeneutical circle, characterized by a repeatedly and cyclically movement between the parts and the whole, and also between both pre-understanding and understanding (Alvesson & Sköldberg, 2005). The hermeneutic circle of interpretation is, therefore, never closed, but is ongoing and may be appropriately described as a hermeneutical spiral illustrating that the interpreter never returns to the same point twice.

As mentioned above, the empirical phase of the study rested on a specific frame of reference that included my own pre-understanding and my theoretical perspective. During the interviews, I asked each nurse questions and I listened attentively to their responses. I aimed at being intuitively present, creative and aware, and during this process new ideas and associations arose. I (re)turned to the research literature and to theory. Some preconceptions and theories were strengthened, some were further developed and some were rejected. I read, searching the literature in more detail, and I (re)turned once again to the empirical field, inviting another participant to tell his/her story. In this way, the hermeneutical spiral took another turn and continued to evolve. Gradually, I came to an understanding of the essence and the meaning of the nurses' stories, and I decided on which theoretical perspectives and concepts I needed to use in order to look at, understand and discuss the empirical data.

4.2 Methodological consequences

The clarification of ontological and epistemological issues leads to methodological consequences, some methods are included, whereas others are excluded (Bengtsson, 2006a). In this study, discussions about methodological consequences rested on the phenomenological idea that it is the phenomenon itself, as well as its characteristics, that will determine the choice of a suitable methodology. The method is a tool that is chosen to best suit the current study. Following on from this, is the need to be creative, developing methodological strategies according to the phenomenon one wishes to explore (Bengtsson, 1999). In this research study,

I explored nurses' experiences of own job engagement in community health care. Prior to commencing the empirical phase, I had chosen to employ the perspectives that had emerged from my thesis, and before the data were collected, I had also partly defined the strategy of analysis that I planned to use (see section 4.4). As Østergaard (1998) points out, however, in an explorative design, the methods can only be defined and developed to a certain degree before the research project starts. As the nature of the phenomena being studied may change during the course of the project, making it appear different from how it was originally perceived to be, the method will need to change accordingly. This makes detailed decisions about the methodology early in the project not only difficult, but contraindicated (Hauge, 2004). Qualitative methods, as opposed to quantitative methods, are flexible to some degree in both form and structure, and they need, therefore, to be adapted to the current study. The inherent strength of this lies in the developing of an instrument precisely to the study's purposes and aims, and to the collection and analysis of the empirical data. Although, while the strength of qualitative method is its dependency on context, it is, at the same time, its weakness (Østergaard, 1998). Being dependent on the specific research purposes and the researcher conducting the study, raises doubts as to whether the findings of qualitative research can be of general interest. In order to address these doubts I will discuss the suitability of the methods chosen, here and in the discussion section of this dissertation. In this dissertation, I will also present the choices I made at the beginning of the study and the changes found necessary during its course.

4.3 Data collection

4.3.1 The qualitative research interview

The study employed an explorative qualitative design in which data were collected with tape-recorded in-depth face-to-face interviews. The purpose of the qualitative research interview is to collect data about what importance and meaning the interviewee attributes to different conditions in his/her own life (Fog, 1999; Kvale, 1997). The point is, therefore, that the interviews shall result in interpretations of the nurses' descriptions, in an effort to understand the meaning of job engagement in the lives of the nurses interviewed. Thus the interview is a bridge providing entry into the nurses' life world.

The interview technique applied in this study combined a phenomenological approach (descriptions), and the hermeneutic technique (interpretations) (Van Manen, 1990). The phenomenological approach was used because I wanted to be alert and tuned towards how things appear in the nurses' life worlds, while the hermeneutic technique was employed because I also wanted to gather the nurses' own interpretations of their experiences. The combined use of these two approaches therefore enabled me, to not only invite the nurses to tell about and describe their stories, but also to invite them to reflect upon the meaning of their experience during the interviews.

According to Krogh (1995) the aim of the in-depth interview is to reveal meaning and to develop knowledge through a well created and well-performed, moral dialogue. Following on from this, my intention was to refine the interviews in the direction of becoming dialogues. I could not, however, escape the fact that the researcher and the interviewee did not have equal positions and responsibilities. As I was the one who decided the themes to be pursued, and who critically followed up the nurse's responses, I also defined and controlled the situation, something that Kvale (1997) underlines as a characteristic of the qualitative interview. I aimed at making it possible for the nurses, however, to come forth as "whole" persons and to give them time and space to tell their stories as fully as possible. I asked them questions concerning their experiences and I invited them to expand on, and to elaborate their stories. Further, I pointed out things the nurses told me that resembled, and were different from, my own experience and in this way, we occasionally came close to having, and sometimes really did have, a dialogue.

4.3.2 Sample: the story of who I was looking for and whom I actually recruited

In order to be able to sufficiently explore the phenomena in question it is important to find people who best represent the phenomena that are to be studied (Kvale, 1997). The participants in this study were Norwegian community nurses who were nominated by colleagues based on the three main recruitment criteria:

1. the nurse was known to thrive in difficult working circumstances
2. the nurse expressed enthusiasm on the job
3. the nurse was vigorous and highly committed to work

I was primarily looking for nurses who had been working at their present workplaces for at least one year. While both men and women were of interest, my focus was on finding individuals who filled the criteria for the study. I therefore did not consider recruiting equal numbers of men and women as my focus was not on gender. I considered it important to recruit nurses from different workplaces, so that cultural characteristics from one or two worksites would not influence the sample.

In town A, I invited the nurse manager of a nursing home to nominate employees according to the three criteria above. Three nominees from different wards were sampled from this nursing home, and two public health nurses in town A were added using snowball sampling[2]. In town B, I contacted the head of the municipal community care service, who in turn contacted nurse leaders in several home care divisions and nursing homes. This resulted in the selection of two participants who worked in two different nursing homes, and three others who were employed in three different home care divisions operated by the municipal health service. The eleventh participant was recruited from a nursing home in nearby town C, based on snowball sampling. Participants' ages ranged from 24 to 63 years, and years of work experience ranged from 1.5 to 41 years.

I contacted each participant by phone and they were all briefed orally and thereafter in a letter about: (1) the study, (2) why and how she/he was recruited, (3) the time needed to participate, (4) the guarantee of anonymity and confidentiality and (5) of the right to withdraw from the study at any time (see attachment I). In the letter, I also explained that I would contact them by phone in five to ten days to arrange the time and place for the interview. The participants were also welcome to contact me earlier if they so wanted. The study was approved by the Norwegian Social Science Data Services (Ref. no. 9800) (see attachment II). Further, the study was presented to the secretary of the Norwegian National Committee for Research Ethics - the Southern region - in a telephone conversation. This consultation established that there was no need to seek ethical approval for this study, as it did not involve patients or vulnerable groups, nor would direct health-related issues of the nurses be focused on.

[2] Snowball sampling is a type of convenience sampling, also called network sampling (Polit & Hungler, 1995; Weiss, 1994). This sampling approach is usually referred to when early sample members are asked to identify and refer other people who meet the sample criteria. In this case, nurses were identified by people who attended lectures where I presented this study. I contacted the head of their work-sites and asked permission to contact the nurses and invite them to join the study.

Approval was, however, attained from the head of municipal community care service and from nurse managers to conduct the study at their respective work sites.

This recruitment process provided me with a strategically chosen purposive[3] sample of eleven nurses working in diverse community health care services from three different towns and eight different work-sites. Eight nurses were selected based on nominations from nurse managers. Three were selected based on the same criteria, but via snowball sampling. One might say that the idea was to recruit the 'superstars'. The eleven nurses all agreed that they fulfilled the criteria for participation in this study. Surprisingly, at least to me at the time, it turned out that nine of the nurses had previously experienced shorter or longer periods with the symptoms of burnout. One might argue, however, that all nurses in community health services will be, to some degree, at risk of burnout. Current research shows that nurses, along with other caring professions, are particularly threatened by this (Roness & Matthiesen, 2002). However, there are many examples of workers who nevertheless thrive, under difficult working circumstances. A central premise of this study was that there is potentially much to be learned from such nurses, hence the attempt to recruit these vital and enthusiastic persons. It was not my intention to recruit vital and enthusiastic nurses *with* a history of burnout symptoms, but nine of the nurses had such stories to tell. These periods had forced them to change jobs, to change careers and to reduce working hours. Further, many of them had periods of sick leave, ranging from a couple of weeks to a whole year. One of the participants, recruited by snowball-sampling, told me during my follow up phone-call with her, that she had experienced severe burnout-symptoms some years earlier. In fact, she referred to this period in her life as her period of being burned-out. At the time of recruitment to this study she was working again, and said that she fulfilled the recruitment-criteria. She was the only participant I new of who had experienced burnout prior to the interview. The fact that eight more participants had experienced different degrees of burnout symptoms opened up new possibilities in the analysis and interpretations of the data. This made it possible to analyse the data not only in relation to 'zest for work', 'vitality', and 'calling', but also in relation to self-care and re-gaining job engagement.

[3] Purposive sampling is based on the belief that the researcher's knowledge about the population can be used to hand pick the persons to be included in the study (Polit & Hungler, 1995). The aim of this study was to purposely select nurses who were judged to be particularly knowledgeable about the phenomena under study.

Data were collected through fifteen, tape-recorded in-depth interviews from December 2001 to September 2004. The participants chose where the interviews were to be conducted. Eleven of the interviews were carried out in offices at the nurses' workplaces, while four were conducted in the nurses' own homes. The duration of the interviews varied from forty-five minutes to two hours, with an average of one hour and thirty minutes. Four nurses were interviewed twice. Two of these nurses were interviewed with a two-week interval. They were the first two nurses to be interviewed in the study. It was thought that a second interview would give the nurse the opportunity of going into more detail in specific areas of their own choice, and to go deeper into themes of interest that arose during the preliminary analysis of the first interview. These two second interviews were, however, the shortest ones of the interviews conducted, and little new information was revealed. Therefore, the choice was made not to continue using this interview method. Two nurses were, however, interviewed twice later in the study, with intervals of respectively one and a half years and two years. These interviews had two main objectives: first, to explore issues concerning the experience of symptoms of burnout and self-care, and second, to present the preliminary findings and ask for the nurses' feedback.

It appears that interviewing participants can continue forever. How do I decide when I have interviewed enough nurses? Weiss (1994, 21) provides an answer; *" In general, when further inquiry will add little to the story, stop inquiring."* Saturation point also depends on the heterogeneity of the sample. When interviewing nurses number ten and eleven, I experienced that the stories they told added little to what I already knew. In other words, the returns were diminishing. I evaluated variations in the group concerning age, years of working, further training and education, current job position etc and concluded that I had recruited sufficient participants to explore job engagement to the extent needed for the purpose of this study. Further, in order to justify the time spent invested in interviewing I thus decided to stop including more participants.

4.3.3 Interview guide

For the purpose of the interviews a thematic interview guide was constructed (see attachment III). It contained a sketch of the themes relevant to the phenomena being explored, and some examples of relevant questions to ask concerning each theme (Kvale, 1997). The questions were asked in a conversational style with the aim of inviting the participants to speak as freely

as possible, telling their stories and describing their experiences. Apart from a major change following after the first three interviews, the interview guide changed only slightly during the course of the study, although the opening question was always the same: "Can you please tell your work-life story?" The starting point of the interview guide was, therefore, "the full story of the nurse's work-life". Thereafter, the interview focused increasingly on specific themes. The interview guide was constructed with the aim of focusing on the nurse as a 'whole' person, holistically speaking. It was my task to provide the opportunity for the nurse to describe the phenomena in terms of his/her thoughts, feelings and bodily experiences. Questions such as; "How do you experience…?", "Can you describe what you think/thought when….?", "What did you feel…?", "How does it feel in your body when…?" "Can you expand on…?" "How do you feel about…?" were asked so as to invite the nurse to elaborate on his/her experiences.

The interview guide was divided into four themes for the first three interviews:
1. The work-life story
2. Zest for work
3. Calling
4. Vitality

Following these interviews, two new themes, which the nurses had repeatedly referred to, were added to the interview. These themes were:
5. Meaning and values
6. Self-care

I chose to include these themes in the interview guide so as to guarantee that the remaining participants would be invited to also tell their stories of self-care and of the meaning and value of life and work. Although the themes were the same, the questions differed from interview to interview. The interview guide was used primarily as a mental guide (Fog 1999). Using the interview guide this way required some preparations before interviewing. It usually involved a quick walk, followed by a short meditative sequence in which the interview situation was visualised as a relaxed and creative conversation. I pictured myself as a careful listener who followed up interesting themes and invited the nurse to speak freely, while the nurse was pictured as relaxed, comfortable and willing to share his/her stories (Vinje, 2002).

4.3.4 Self-reflection and conducting a research dialogue

The qualitative research interview calls for a careful ask-and-listen approach (Kvale, 1997). It is necessary to be aware of who the researcher is, both as a researcher and as a dialogue partner (Fog, 1999). The researcher carries *something* with him/her into the dialogue. This *something* may be considered a filter in which the intention of being open, exploring and turned to 'the things themselves', will be filtered through. To the degree that the researcher carries both unconscious ways of reacting and non-processed emotional experiences to the research dialogue it could obscure, for example, the intention of being open. Preparing for this kind of interview therefore requires an approach that is more than theoretical and practical. Self-scrutiny is also necessary. Thus, the qualitative research interview requires a degree of personal and inter-personal competence, and the researcher is considered to be the most important instrument of data collection. From this understanding, Fog (1999) raises the problem of meeting one's prejudices in others, and the need, therefore, for self-examination. If the researcher is to create an atmosphere of trust and openness that is necessary for in-depth conversation, she will need to use and refine her senses. In this study I used a combination of meditation, visualizing and writing, usually preceded by a quick walk, in order to prepare myself for conducting the interviews. Before and during the interviews, I experienced how a fear of being clumsy sneaked upon me. At the same time, I was very enthusiastic about interviewing these particular nurses who had a reputation of being full of enthusiasm, of having a zest for work and of having vitality. Moreover, I acknowledged and reflected on the danger that I might only hear that which suited my pre-conceptions, and thus fail to be open enough, to be explorative, and to focus on possible nuances. The realizing of this increased my awareness during the interviews.

For the most part I posed open questions, and invited the nurses to tell their stories. The majority of the nurses told relatively long stories, and seemed to have a lot to tell, and except for two of them, the nurses seemed to find it easy to talk openly. It was important for me not to interrupt the nurses as they were thinking, telling and reflecting about their stories, as long as they remained within the themes of the dialogue. When sharing my own views during the interviews it felt natural and comfortable. However, two of the nurses appeared less talkative. They seemed to be a little unsure, as if they were trying to give the responses they thought I wanted to hear. During the interviews with them, I sensed how the situations became tense for them and for me, and I worked hard to find new relevant and open questions that would help them to tell their stories more freely. As Kvale (1997) suggests, I made the interview dialogue

as self-explanatory as possible by paraphrasing what the nurses said and asking for their confirmation or invalidation of my understanding.

During the interviews, I experienced that I was not an empty receiver of the stories the nurses told me. What they said resonated in my body and in my feelings and it spoke to my values. I was present in the dialogues with my own life and my range of experiences. I could feel it physically when one nurse spoke of the energy that flows in her body when life is "swinging", and I could recognize the feeling of exhaustion when another described her experience of burnout. I felt that I understood what another nurse meant when she described how knowledge and wisdom emerged from silence. At the same time, the extent to which I was able to seize and understand the nurses' experiences, was dependent upon the degree to which I was able to be open and questioning.

4.3.5 From lived experiences, to speech and to written text

To transcribe is to transform oral dialogue into written text (Kvale, 1997). The interview transcription is a frozen version of the vivid and ambiguous communication between two or several persons (Fog, 1999), and is necessary in order to provide the researcher with a fixed point to return to in the process of analysis and interpretation. The interpretation of meaning of the qualitative interview is, however, also dependent on a living context (Østergaard, 1998). I therefore listened to the recorded interviews repeatedly, as I felt that the written text alone served as an incomplete source.

The presence of the tape-recorder underlines the fact that research interviews are not ordinary conversations. The conversation was always a bit slow in the beginning when the recorder was switched on. Although the flow of speech seemed to be unstrained after a while during the interview, it is possible that the presence of the recorder increased the distance between the interviewee and the interviewer without it being made known. All the conversations continued for a while after the tape recorder was switched off, and in the cases where the post-conversation was particularly relevant to the study, I asked if it was alright that I took some notes. These notes were kept alongside the transcriptions and were included in the analysis.

The first two interviews I transcribed myself. Thereafter I chose to have the three next interviews transcribed by a skilled typist. When reading these transcripts, however, I discovered that words and phrases from the recorded interviews were misinterpreted or missing. When listening to the taped interviews again, the conversations came to life once more. I recalled the atmosphere, the movements, the glances, the eye contact and the shifts in facial expressions. I was therefore more able to grasp the words than the typist was when the living context was awakened. In writing out these transcriptions I also started the process of analysing. Due to the above reasons, I decided it was important to transcribe the remaining of the interviews myself.[4]

The interviews were transcribed verbatim. According to Kvale (1997) the choice of transcription style depends on how the transcriptions shall be used. I chose to transcribe the recorded texts word-for-word, using exactly the same words and phrases that were spoken, including "hm-s", repetitions, pauses and the length of some of the pauses. This was done in the phenomenological spirit of turning to 'the things themselves' and being true to them, in order to have a starting point for conducting the analysis that most truly represented the recorded interviews. The respondents read and approved the completed transcriptions. Kvale (1997) raises the question as to whether the participants' reading and approving of the transcriptions strengthens their validity. In this study the nurses were given the transcriptions to read so as to have the opportunity of expanding and deepening their thoughts and ideas, and to ensure that their experiences and the meaning they had wanted to convey was represented by the transcribed text. I sent the transcribed interviews to each nurse, with a stamped and readdressed envelop, and invited them to read through the transcriptions and to return them to me with their comments (see attachment IV). The nurses were also asked to comment on how they had experienced participating in the interviews. Some ethical considerations are associated with the transcription process and with asking the participants to read the transcriptions, and these will be discussed in section 4.6.3.

[4] One interview was not recorded due to equipment failure. Notes were taken after the interview, and a subsequent phone call to the nurse established their accuracy. The notes provided a general impression of the interview.

4.4 Qualitative content analysis

In qualitative research method, analysis is considered to be an integral part of all the phases of the study, including the design of the study, the conducting of interviews, the analysis of the empirical data, and the writing up of the study (Alvesson & Sköldberg, 1994). This section will deal with the analysis of the empirical data.

Based on Husserl's phenomenology, Amedeo Giorgi (1999) has developed a model of analysis of qualitative data. Giorgi uses a phenomenologically-based meaning condensation with a description of the essence of the phenomena being the goal of the analysis. This model does not, however, take into consideration the historicity and culturally dependency of the researcher and the interviewee as I have accounted for above. As this method nevertheless can be helpful in analysing long and complex texts (Kvale, 1997), I chose to let the analytical tool of the study be inspired by Giorgi's five-step model of phenomenological analysis (1999):
1) a general impression of the interview
2) dividing the text into fragments of meaning
3) transforming the fragments of meaning
4) a specific description of the essences of the phenomena and
5) a general description of the essences of the phenomena

I decided in the end, to employ Giorgi's analytical model in a pragmatic way. This will be accounted for below. The analytical tool gradually evolved throughout the project, and the analysis was subsequently conducted with both descriptive and interpretive approaches. It will become apparent in the following that the final tool of analysis used in this study differs from Giorgi's five-step model in several ways.

Three other approaches used to analyse the data in this study include "*ad hoc meaning generation"* described by Kvale (1997, 135) as one of the most common techniques of interview analysis. *"Ad hoc meaning generation"* allows for a variety of approaches and techniques in order to generate meaning from interview texts, and includes "*meaning condensation", "meaning categorizing"* and *"in-depth interpretations"*, which are used in this study. The analysis also relies on contributions from *"qualitative content analysis"*, as presented by Graneheim and Lundman (2003). Finally, the analysis combined "*case-focused"* and "*cross-case issue-focused"* analysis (Weiss, 1994), which involved analysing the phenomena as described by each participant, and thereafter analysing across participants.

4.4.1 The analytical tool

Step 1 of the analytical tool was divided into *two steps*, step 1a and step 1b, the first step being more 'general' than the second. I approached the data material gradually, as though I was peeling an onion layer by layer, gradually coming closer to revealing the content and the meaning of the text. In steps 1a and 1b, the purpose was to gain an overall impression of the material in order to provide a foundation for the following steps. In steps 2-5, each interview was analysed, in-depth, in regard to the eight main analytical dimensions presented below. Codes and categories were created case by case and cross-case, and during this entire process themes and sub-themes were identified. Giorgi's ideas are present in steps 1a, 2 and 3, while Graneheim and Lundman's ideas are present in steps 1b, 4 and 5 along with those of Kvale and Weiss.

Step 1a: Gaining a general impression of the interview

The purpose of this first step was to gain an overview of and insight into the immediate themes of the interviews (Giorgi 1999). Each interview was listened to and reread several times to obtain a sense of the whole. The hermeneutical spiral was evolving. I had moved between empirical data and theoretical perspectives for a long time, conducting the analysis more superficially by attempting to gain a general impression of the material and from time to time taking an in-depth dive into fascinating areas of the texts. As a consequence of this endeavour the interview guide had undergone some changes. The dimensions 'self-care' and 'meaning and values' had emerged, and the reading of literature and research on these subjects was a parallel task, as was the acquisition of different theoretical perspectives on the other areas.

Step 1b: Gaining a general impression of the interview

During the first three interviews, the text was read in the light of six content areas that functioned as an analytical lever. A content area is understood by Graneheim and Lundman (2003, 106-107) as: "*a specific explicit area of content with little interpretation. A content area can be parts of the text based on theoretical assumptions from the literature, or parts of the text that address a specific topic in an interview."* In this study the content areas were the nurses' 'work-life stories', their experience of 'zest for work', of 'vitality', of 'calling', 'meaning and values' and 'self care'. These areas were taken from the interview-guide and thus reflected my preconceptions and theoretical frame of reference. The content areas that

served as an analytical lever were meant to open up for the analysis of new dimensions beyond the six content areas.

When analyzing each interview, I had the other interviews in the back of my head. They contributed to my understanding of the interview text before me. I asked myself: 'what is this about?' 'What strikes me as prominent and important?' 'What is she really expressing?'' "What else is she saying?' 'What else do I see and hear?' 'Is this about something else?' I tried to let the transcribed text speak to me. I divided a sheet of paper into two, calling the two sides respectively 'Descriptions' and 'Interpretations'. I searched for the nurses' descriptions within the different content areas and wrote down key-words and phrases. I also wrote down my own immediate interpretations, and all the questions, ideas and associations that occurred to me. At the end of each interview I wrote an analytical summary. These notes and summaries were kept together with the respective transcriptions. Following the completion of the three first interviews, two more analytical dimensions emerged: 'growth, development and learning', and 'contributing'. The remaining interviews were analysed using the same procedure, and including all eight dimensions. On completion of this phase of the analysis, I proceeded to the next level of the analysis, which was more in-depth and detailed. This involved analysing the text dimension by dimension, case by case.

Step 2: Dividing the text into fragments of meaning (meaning units)

The second step was a spontaneous and intuitive division of the text into fragments of meaning, marked by numbers (Giorgi 1999). In this step, I continued to aim at being true to the descriptions of the participants to ensure that the richness and the complexity of their experience were well-represented. Meaning units are considered to be unique, contextual and newly discovered expressions, still in the language of the respondents, and should not, according to Giorgi (1999), be coloured by the researcher's perspective. While the division of the text into meaning units supposed to be spontaneous and non-theoretical, I admit that, to some extent, I may have seen meaning in the text in a different light due to my own perspectives.

Step 3: Transforming the meaning units

The third step was the process of transforming the meaning units into theoretical expressions while still preserving the core of the nurses' original descriptions (Giorgi, 1999). This was

done by theoretical reflection, and by looking upon the meaning units as creatively and intuitively as possible.

Step 4: Meaning condensation and the creations of codes and categories
When the condensed text is made abstract it includes the creation of codes and categories (Graneheim & Lundman, 2003; Kvale, 1997). In this phase I attempted to make interpretations on a higher abstracted level, while aiming at the same time to give a faithful description of the phenomena as they appeared to me. This process went back and forth between transformation and condensation in the search for the characteristics and meaning of the phenomena being explored.

Step 5: Searching for themes, understood as the expression of latent content
Content analysis often includes interpretations of the latent content (Graneheim & Lundman, 2003, 107): *"We consider a theme to be a thread of an underlying meaning through, condensed meaning units, codes or categories, on an interpretive level. A theme can be seen as an expression of the latent content of the text."* As a theme refers to that which a text speaks indirectly of, the search for themes, involves interpretation of the underlying meaning of the text.

Although this process is described in a linear way, it proved to be a spiral-like process, as described in section 4.1.2, where I repeatedly and cyclically moved between steps and between cases, and between working with the transcribed interviews and reading literature on topics related to the phenomena being studied. The texts were divided into meaning units that were transformed and condensed, case by case. Further, the condensed meaning units were sorted into codes and categories, case by case and cross-case. The results of this endeavour comprised the manifest content of the text. The themes, however, representing the underlying meaning, or the latent content, of the entire material, emerged as the analysis proceeded; sometimes I grasped them spontaneously or in an intuitive way. I would, therefore, describe the emergence of the themes as the result of combining a logical-analytical approach with an intuitive-meditative approach throughout the entire analytical process.

For a further account of the analytical process please see the example provided in attachment V.

4.4.2 Reflective approach and attitude

Seizing the 'things themselves' implies entering into the interview texts as deeply as possible to reveal the secrets of the data (Østergaard, 1998). I discovered that the data material spoke to me in relation to important things in my life, resonating in me due to my personal life experiences and my theoretical frame of reference. The relationship between the openness of phenomenology and interpretation in hermeneutics provides an analytical challenge that involves approaching the interview texts from both a descriptive and an interpretive level. I entered into, and became a part of the hermeneutical spiral, alternating between my preconceptions and my theoretical understanding, striving to be true to the phenomenological ideal of openness, yet acknowledging the impossibility of transcending the life-world in which I am 'always already' a part. This two-fold approach increased the importance of being self-reflective. In response to this I developed a combined analytic approach in which I alternated between logical-analytical thinking and intuitive-meditative thinking. I wanted to make optimal use of my intuitive and creative abilities to seize wholes and coherences on one hand, and to use my logical and analytical skills on the other. My intention was to explore, and enter into the phenomena being studied as fully and deeply as possible. I aimed at refining my senses so as to see, hear and seize the voice of the 'things themselves'. At the same time, I felt the need to challenge and refine my ability to sense the extent to which my preconceptions formed the main basis of my interpretations.

After listening to each interview, I 'invited the conversation' into a meditative sequence in which I posed the question, "What is this about?" I also included meditative sequences were I wondered; 'had I drawn conclusions about the specific codes, categories and themes too quickly?' 'Was I seeing what I saw only as a result of my preconceptions?' Most of the time, I knew intuitively when I had reached descriptions and interpretations that faithfully represented the nurses' stories, and I was able, therefore, to identify and remove preliminary interpretations that were not true to the 'things themselves'. At the same time, my awareness of the fact that my conclusions were not independent of my personal and theoretical frame of reference also increased, and I realized that if my perspectives changed the 'things themselves' might speak to me in a different way. I can not say that clear glimpses of insight and new understanding always came to me during meditation; although I did experience that the analysis that followed meditation was unstrained and seemed to float easily. Meaning revealed itself relatively effortlessly.

4.5 Research quality: validity and reliability

For some time there has been, and still is, an ongoing discussion in qualitative research regarding verification strategies for establishing reliability and validity in qualitative research (Kvale, 1997; Malterud, 2001; Morse, Barrett, Mayan, Olson, & Spiers, 2002). Some qualitative researchers suggest the substitution of reliability and validity with the parallel concepts of 'trustworthiness' and 'confirmability' (see for example Thagaard (2003)) arguing that reliability and validity are terms pertaining to the quantitative paradigm. These discussions are, however, ultimately about the extent to which findings in qualitative research can be said to be true. Here, I will not discuss the use of the above concepts except to state that I consider the terms validity and reliability suitable terms to use in accounting for the rigor of qualitative research.

Morse and colleagues (2002) and Kvale (1997) argue that verification strategies should be an integral and self-correcting aspect of the study itself. This view is in line with suggestions for conducting reflective research and using reflexive methodology presented by Alvesson and Sköldberg (2005), and reflexivity[5] presented by Malterud (2001), whereby the ensuring of rigor is attained through the use of strategies inherent in the chosen qualitative design. The influence that the researcher has on a study is, therefore, closely related to the validity and reliability of qualitative research. To the extent that it is meaningful to distinguish the concepts of reliability and validity, Fog (1999) points out that reliability is often seen as a premise for validity. Reliability has to do with the consistency of the research findings (Kvale, 1997), and it has also to do with the relationship between the researcher and the interviewee on the one hand, and between the researcher and the transcribed interviews on the other (Fog, 1999). In order to establish the reliability of this study, I have provided, in this method section of the dissertation, an ongoing and detailed description of my role as an instrument of data collection and an analytical tool. Moreover, I have attempted to guarantee the inner logic and consistency of this study by working coherently from the ontological level to the practical level.

[5] Reflexivity is defined by Malterud as: *"An attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process"* . A metaphor for reflexivity is *"the knower's mirror"*. Thus, reflexivity addresses factors such as *sharing preconceptions* and *establishing meta-positions* in order to create adequate distance from a study one is personally involved in (Malterud, 2001, 484).

4.5.1 Subjectivity - reflexivity

In applying the Epochèen, Husserl argued that it is necessary for the researcher to limit his/her influence on the research process to a minimum (Bengtsson, 2006a). According to Heidegger, however, one cannot escape one's pre-understanding of, and relationship to, 'the things themselves'. The ontological position in this study implies that I, as researcher, cannot transcend the world in which I am conducting research. Phenomena therefore, can not be viewed objectively, but only subjectively. At the same time, Hauge (2004) emphasizes the necessity of being aware of one's own subjective influence on a study, while Kvale (1997, 143) underlines the importance of avoiding *partial subjectivity* where the researcher sees only evidence that supports his/her own ideas and conclusions. When applying a self-reflective attitude, working systematically and communicating with others it is suggested that the researcher is able to transcend her preconceptions, to expand her horizons, and to avoid undesired subjectivity (Alvesson & Sköldberg, 2005; Hauge, 2004; Kvale, 1997).

In addition to applying a critical, self-reflective attitude in this study, I also attempted to falsify my conclusions by engaging in reflective and systematic discussions with advisors and with colleagues at research seminars, and by addressing the issue of undesired subjectivity. The study, including the methods and the findings, were also discussed with nurses and colleagues from other professions at lectures, workshops, seminars and conferences. This was in order to increase my awareness of my own professional standpoint and to have my ideas and perspectives challenged by others. Two of the nurses in the study were also invited separately to join me in these discussions. As stated above, these dialogues were a combination of in-depth interviews on issues concerning the experience of symptoms of burnout and self-care, and conversations regarding the preliminary findings of the study. Some researchers argue that member checking might actually threaten the validity of a study, as feedback provided by participants may lead the researcher to focus more on the descriptive accounts of the participants and less on making abstracted interpretations (Morse, Barrett, Mayan, Olson, & Spiers, 2002). During these dialogues, I presented the nurses with an overview of the categories, themes and sub-themes that had emerged from my analysis. My aim was to provide them with an overall impression of the preliminary findings, and to invite them to respond to my interpretations. This resulted in engaging dialogues in which the two nurses emphasized aspects of the interpretations that were important to them, and they both expressed a feeling of having been understood.

4.5.2 Generalization - transferability

Kvale (1997) claims that the demand for the generalization of knowledge has its roots in a belief in the importance of precise, universal knowledge. Today, a view of knowledge as contextual, diverse and complex, has replaced to a large degree, the traditional perception of knowledge as universal and precise, and therefore the demand for the generalization of a study has also changed. Instead of using statistical generalization, which is dependent upon different methods of sampling, a qualitative study employs analytical generalization. The power of analytical generalization lies in providing the reader with a detailed presentation of the research findings and in making the arguments as explicit as possible so that the reader himself can judge whether the knowledge presented may be relevant to other settings (Kvale, 1997).

In relation to the present study, this means determining whether the findings say something about job engagement, and about maintaining and sustaining job engagement through self-care for other nurses in community nursing, in other areas of nursing, or in other professions. I have attempted to provide a detailed presentation of this study's findings in the three papers respectively, and to make the arguments for and against the transferability of the findings as explicit as possible so that the reader may judge whether the knowledge presented may be relevant to other settings. In addition, Malterud (2001, 485) argues that; *"the study design should show a thorough consideration of what an adequate degree of transferability would be, in view of the assumptions of the research question, and represent a relevant sampling strategy"*. I have, therefore, also attempted to present the entire research process in a detailed and thorough way in order to further enable the reader to determine the transferability of the findings. A more specific account of the arguments concerning the degree to which it is possible to generalize is provided in the discussion section of this dissertation, and in the three papers respectively.

4.6 Ethical considerations

Four main ethical principles need to be considered when conducting research with human participants. These include: the right to voluntary participation; participation by informed consent only; the right not to be exposed to risk and hazard; and the right to the protection of privacy (Alver & Øyen, 1997; Kjønstad & Syse, 1994; NEM, NENT, & NESH, 1996). These principles have been addressed to some degree in section 4.3.2, as well as in the there papers.

Ethical considerations regarding the qualitative research interview in particular, however, are discussed below in relation to issues concerning differences in power, the interview conversation as research versus therapy, and issues relating to the transcription of the interviews.

4.6.1 Moral issues and differences of power in the qualitative research interview

The researcher and the interviewee in the qualitative research interview are not equals, as they would be in an informal, confidential conversation (Kvale, 1997). In order for a research dialogue to be conducted in a moral way, the unequal relationship between researcher and interviewee needs to be recognized and accounted for. The creation of a morally sound research interview sets the framework for the way in which the conversation is to be conducted and used (Fog, 1999). One important challenge raised by Fog (1999) concerns the dilemma where the openness of the researcher and the trust she establishes in the interview situation, while desirable for the in-depth exploration of a phenomena, may also result in the nurse revealing private, normally untouchable issues. Empathy, moral awareness and self-reflection are required on part of the researcher, in order to sense when the participant is in danger of revealing personal information that is not relevant to the interview.

To increase my awareness of how the nurses' experienced the interviews, I attempted to conduct the interviews without using the interview guide directly. This enabled me to be more aware of their verbal and non-verbal responses and in this way I aimed to keep the nurses from revealing more than they felt comfortable with. During one interview, however, this was not possible. The nurse concerned commented on this in her written response to the transcription, where she described a feeling of discomfort, of having presented herself as self-righteous in her efforts to describe her experience. She reported that thoughts and feelings that she had been unaware of had been awakened in her, and that she had needed to spend some time reflecting upon this following the interview. I telephoned her, asking whether she wanted to talk about her reactions, which we did. I informed her that she could contact me again if she needed to talk further.

4.6.2 The interview conversation as a method of research versus therapy

While there are certain similarities between a conversation as a form of method of research and as a form of therapy (Fog, 1999; Kvale, 1997), the interviews in this study had, of course, no planned therapeutically goals. During the course of the interviews, I experienced that the nurses and I developed a degree of closeness through their sharing of their experiences. I was concerned as to whether the experience of feeling close to a person previously unknown to them, may have caused the nurses to feel awkward following the interviews. This was one of the reasons for deciding to return the transcribed interview-texts to the nurses (see below), and inviting them to comment on their experience of being interviewed. The nurses' experience of being interviewed also formed part of the debriefing discussions following the completion of the formal interviews, when the tape-recorder had been turned off. The nurses were also invited to contact me by phone if they wanted to talk about issues related to the interview itself, or to the specific interview situation. While none of the nurses contacted me by phone, they all commented on their experience of being interviewed, either directly following the interview, or by letter, or both. The majority of the nurses reported they had found that the interviews had had a consciousness-raising effect on them. Four of the nurses also emphasized explicitly the therapeutic nature of the dialogues. When commenting on the interviews' similarity to therapy, the nurses did so in a positive way, glad to have become aware of such important issues concerning work. That which until now had been lived experience, integrated, pre-reflected parts of their life-worlds, was raised to a new level of meaning through the nurses' own reflections during the interviews, and during the days that followed. One of the nurses even wrote to me one year later, to tell me about important changes that had occurred in her life due to reflections the interview with her had resulted in.

4.6.3 Transcriptions

Oral language and the written language are different. Some interviewees are appalled by reading their own transcribed interviews. Oral language, transcribed word-for-word, may seem disconnected, incoherent and confusing, and some may feel offended by it and not allow the use of his/her statements (Kvale, 1997). In choosing to return the transcripts to the nurses for them to read, approve and comment on, I specifically pointed out in an attached letter that it may be awkward for them to see their own oral language in the form of written text (see

attachment IV). I emphasized for them that when I listened to the recorded tapes, they sounded just like a normal conversation.

The production of (seemingly) incoherent, stuttering, stumbling and repetitive word-for-word interview transcriptions may result in unethical presentations of the participants (Kvale, 1997). As is apparent in papers 1,2 and 3, the citations used to illustrate the findings and interpretations are presented in a more coherent form than they were uttered. This was done in order to safeguard the integrity of the interviewees and to make the citations more coherent for the reader. Regarding the transcripts themselves, it should be mentioned that in the letter accompanying the transcripts, I underlined that necessary changes had been made to assure the nurse's confidentiality. The identity of the nurse was changed in the transcriptions and the true identity was not kept alongside the transcriptions.

5 FINDINGS

5.1 Paper 1: Community nurses who thrive: the critical role of job engagement in the face of adversity

This paper presents the findings and interpretations from the analysis in the interview study which answers the first research question: 'How do thriving nurses experience job engagement?' The aim was to explore job engagement as experienced by thriving community health nurses, and to explore the processes that promote job engagement among these nurses. The findings and interpretations are based on data from fifteen qualitative in-depth, face-to-face interviews with eleven nurses. The overriding, general impression gained from the data was that all the participants appeared to be very aware people who seemed to live by high ethical standards that guided their nursing practice. The awareness of calling and the search for a match between calling and vocation appeared to be the starting point for, and the motivational factor in, the nurses' experiences of job engagement. The analysis revealed a relatively enduring pattern of introspection and reflection, including deep attention to meaning, meaningfulness and values connected to challenges at work, and their experience of job engagement and their attempts to promote and maintain it. According to the nurses in this study, the experience of meaning and meaningfulness is essential to job engagement. Schaufeli and colleagues (2001, 74) define job engagement as a: *"positive, fulfilling, work-related state of mind that is characterized by vigour, dedication and absorption"* . We suggest the addition of the concept of 'meaning' to an understanding of job engagement, and a reorganising of the phenomena that comprise the construct of job engagement. In our formulation, we seek to emphasize that job engagement in the nurses' descriptions is understood as a process rather than a state, in which the search for meaning, the experience of meaning, and holding on to meaning are a driving force:

Existential curiosity/awareness of one's sense of calling (**path to one's search for meaningfulness)** → calling/vocation match → gives meaning to life/living one's values (**experiencing meaningfulness)** → meaning gives zest → and zest provides the vitality needed to be engaged even under difficult working conditions (**holding on to meaning)**.

Vitality has also to do with the energy released within the nurses when they come in contact with that which calls them and pushes them forward. The process of job engagement is brought forth by a talent for introspection and habitual reflection. Introspection and reflection are intertwined processes, which sustain and develop consciousness about values and the meaningfulness of nursing. Thus, the nurses' conscious ethical awareness, sustained by habits of introspection and reflection, appeared to be fundamental for navigating toward job engagement. In the analysis, the importance of meaning for job engagement and a close relationship between values and meaning is supported, consistent with the observations of Maslach and colleagues (2001). The findings indicate that to promote job engagement, acknowledgment of the importance of values and value conflict is vital both before a choice of profession is made and on a relatively continuing basis during one's work life. The data illustrate that it is possible to make introspection and reflection about values and the meaning of work an integral part of working life. We suggest efforts be made to raise existential curiosity, awareness of values, ethical issues, and the meaning of work in regard of staff development.

5.2 Paper 2: Job engagement's paradoxical role in nurse burnout

In this paper, we sought to answer the second research question: 'What is the role of job engagement in community nurse burnout?' The findings and interpretations in the analysis are based on data from the total of fifteen qualitative in-depth interviews with eleven nurses, aiming at exploring whether job engagement may contribute to exhaustion and burnout and not only to health and well-being. A second aim was to explore the processes that might have inhibited job engagement among these nurses.

Despite the fact that the nurses were known to thrive under difficult working conditions, it became apparent that they had histories of vulnerability. Nine of the eleven participants had experienced stress bringing them near burnout, and one of them to burnout. The nurses described burnout experiences of different lengths and intensity. Further, the nurses expressed that a sense of calling was the underlying reason for their choice of profession. Except for one of the nurses, who explained sense of calling in religious terms, the other nurses referred to it more in terms of having special talents, gifts or resources to develop and put to use and of having a life mission to fulfil. High job engagement, which followed from the nurses' feeling of calling to the nursing profession, contributed to a strong sense of duty and heavy self-

demand regarding their own and other's level of performance. However, the sense of duty and the ethical responsibility that they felt, as well as self-demand and their expectations of others' made it difficult for them. Paradoxically, job engagement may not only promote thriving on the job, but may also contribute to a negative process leading to poor functioning.

The analysis revealed that, for the nurses in this study, choosing nursing as a profession helped them to respond to an important existential issue, finding meaning in life. Moreover, the analysis revealed that the need to experience and hold on to meaningfulness tended to overshadow the importance of manageability of one's professional responsibilities. When meaningfulness and manageability were not balanced, in the sense that the nurse's coping resources were exceeded, feelings of fatigue and symptoms of burnout appeared. Importantly, the analysis showed that moral distress is also experienced by community nurses, and not only by nurses working in acute, psychiatric and crisis health care settings, which have been the focus of previous research in this area. This work illustrates that moral distress, leading to near burnout may be exacerbated by a high level of job engagement, and frustration about not living up to one's high ethical standards. It does seem to be a paradox that job engagement can contribute to poor functioning. One explanation might be that the striving for meaning that underlies job engagement also underlies a strong sense of duty, and that this may lead to overload and moral distress when resources are outstripped by (self) demands.

5.3 Paper 3: Deflecting the path to burnout among community health nurses: How the effective practice of self-care renews job engagement

In this paper, research question 3: 'How do thriving nurses maintain and enhance their job engagement?' was addressed and sought answered. The aim of the analysis was to explore the role of self-care in maintaining and enhancing job engagement among thriving community nurses. The analysis reported on in this paper is initially based on data from nine of the eleven community health nurses who reported having been at, or near, burnout at an earlier point in their careers. These data were collected through thirteen in-depth interviews. For these nine nurses, the perceived failures to live up to their own performance demands appeared to contribute to the process of burning out. This, in turn, triggered extensive introspection, sensibility and reflection, leading to coping, avoidance of burnout and enhancement of job engagement. The nurses acted in two ways to regain job engagement. They worked to lower the too-rigorous standards they had set for themselves and for others, and/or they changed

jobs or modified working conditions. This self-care happened on a philosophical level and on a practical level. The data revealed six main active coping strategies that provided the direct means to regain job engagement: 'striving to be a realistic idealist'; 'engaging in meaningful activities alongside nursing'; 'ensuring a place for silence and withdrawn peace'; 'solving emotional problems'; 'learning from experience' and; 'ability and willingness to undertake major change'. The nurses' self-care often combined actions played out in the following way: a nurses' abiding existential curiosity about the surrounding world and about self stimulated self-monitoring and self-tuning in his/her search for coherence. 'Existential curiosity' and 'monitoring and self-tuning' were, thus, the precursors to action:

Existential curiosity → monitoring and self-tuning → active coping

The nurses showed alertness, appraisal and the ability to act to preserve job engagement. This pattern calls to mind the construct 'sensibility', and in the paper we theorise that in people adept at self-care, relatively constant introspection takes place in the form of sensibility, a pre-reflective, pre-verbal ability the nurses use to receive and read the signals from their own bodies, emotions, existential depths and the social environment. This triggers reflection when sensibility 'signals' discomfort, imbalance or incongruence. A key element of reflection is self-monitoring, through which one gains appreciation of how events and feelings are related. This enables self-tuning, accomplished through changes made in their job situation and/or in their own approach to work, that are intended to restore inner harmony. For all nine nurses, reflection led to coping as result of making one or both of the above changes, which led to the restoration of job engagement. We argue that sensibility is an intuitive, yet basic skill, which can be learned.

In this paper, an attempt is made to integrate the findings of this third research question and the previous two research questions based on interview data obtained from the total of eleven nurses and fifteen interviews, and 'The Self-tuning Model of Self-care' is introduced. Common to all the nurses was the feeling of fulfilment they experienced because they had felt called to nursing, and the match between calling and vocation was deeply gratifying. This match set the stage for two processes, one in which job engagement gave meaning, zest and vitality to life. All the nurses were habitually introspective; they recognised how nursing gave meaning to life, and they were motivated strongly to hold on to that meaning. At the same time, their conscientiousness, dedication and sense of responsibility, self-responsibility and

responsibility for others, led them to a work ethic that called for constant improvement and re-doubled effort. This led, in all but two cases, to overload, moral distress, deep fatigue and near burnout (and in one case, to burnout that resulted in long-term sick leave). The path to ever poorer functioning was signalled by feelings of disquiet and discomfort that the nurses recognised, because they were habitually introspective. This triggered sensibility, which in turn triggered reflection when the nurses recognised that something had to be done to hold on to the meaningfulness of nursing.

6 GENERAL DISCUSSION

The detailed findings are presented and discussed in the three papers, and this section focuses on the integrated findings of the study. Also discussed are methodological issues, practical implications and possibilities for future research.

6.1 Overview of the model

The model depicted in Figure 1 is used to organise the first part of the Discussion, moving from the elements on the left to those on the right. The match between calling and vocation seems to act as a catalyst for processes leading simultaneously to high job engagement and to highly diligent dutifulness. When the inner calling of the nurse resonates with, and finds its expression in, his or her nursing practice, it seems to create an inspirational force which sustains and enhances the experience of job engagement. On the other hand, it also heightens the feeling of duty and responsibility, which in turn may inhibit job engagement. The promotion and maintaining of job engagement, is therefore apparently dependent on the nurses' self-care.

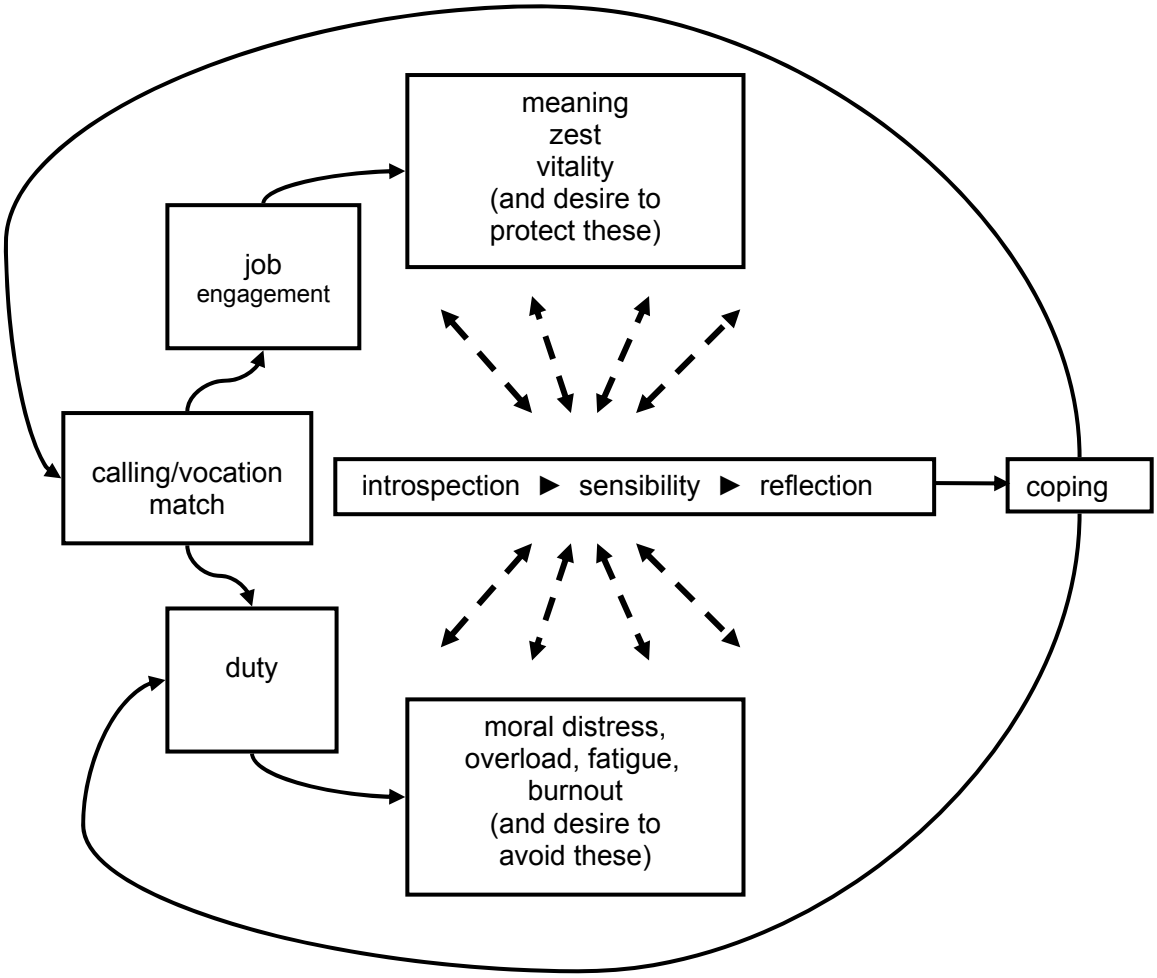

Figure 1: The Self-tuning Model of Self-care (later referred to as the Model)[6]

The Model depicts three parallel processes, one which we characterise as salutogenic, one as pathogenic, and one as a mediating process. The salutogenic and the pathogenic processes both appear to be driven by the same motivational factor, a sense of calling and the calling/vocation match. These two processes are mediated by a third process involving introspection, sensibility, reflection and coping. This is a sensing/reacting process that is adaptive in that it may result in changes (the arrows leading from coping) leading to recapturing job engagement. As pointed out in paper 3, the nurses in this study recognised how nursing gave meaning to life, and they were strongly motivated to hold on to that meaning. At the same time, the nurses' conscientiousness, dedication and sense of

[6] The Model was published for the first time in November 2006, in paper 3. The phrase 'moral distress' has since been added to Figure 1. This change is due to developments in thinking during the interim.

responsibility for self and others, led them to adopt a work ethic that called for constant improvement in their work performance.

The nurses' self-monitoring and the actions it led to were likened, in paper 3, to a self-tuning system as the concept is used in systems science. However, while a self-tuning system provides a useful metaphor for the nurses' self-tuning, its use does have important limitations. As self-tuning mechanical systems are programmed not to exceed preset limits, they can not 'burn out' in the sense that people do, they do not sacrifice themselves and they do not suffer. Nurses, on the other hand, they do engage in self-sacrifice, they do burn out, and their practice of self-care is not mechanical. In addition, it is perfectly possible to design and construct a mechanical self-tuning system, and then create as many perfect copies of it as one wishes, the performance of which will be precisely the same. Human self-care, on the other hand, is inherently personal, and a detailed recipe for self-care developed from the experience of one person is not necessarily suitable for use by others. The Model presented here, therefore, is meant as a devise for organising and communicating constructs, not as a recipe for self-care. This is not to say that self-care cannot be taught, it is indeed taught and this will be addressed in section 6.4.2 of this dissertation. Furthermore, the Model has proved useful to outline topics in teaching self-care, and students in health promotion studies react well to its use. However, they are made to understand that self-care is each individual's practice, and that individual differences in managing self-care may be quite large. The nurses' experience of self-care appears, however, to provide an essential basis for discussions on and reflections around self-care during the teaching of students.

6.2 The Salutogenic Process

I have borrowed the concept of salutogenesis from Antonovsky (1979; 1987) to describe the process whereby nurses appear to be protected from the adverse effects of stress (the rigours of nursing). This process begins with the calling/vocation match (which has its roots in a sense of calling), which promotes job engagement, and which in turn promotes meaning, zest for work and vitality. Ironically, and as depicted in the Model, the initial element in the salutogenic process is also the initial element in the pathogenic process, as discussed later. At this point, however, it is necessary to say something about the salutogenic construct, the Sense of Coherence (SOC), as the Model does not include SOC in any direct sense.

It would have been possible to analyse the nurses' stories by employing the SOC construct and searching for expressions that matched Antonovsky's (1987) concepts 'comprehensibility', 'manageability' and 'meaningfulness'. In this study, however, the construct 'job engagement' and the concepts of 'calling', 'zest for work' and 'vitality' comprised the main theoretical frame of reference. Salutogenesis played a different role in the study, by providing a health promotion perspective, through the thought provoking questions by Antonovsky (2000, 12): "How do we manage to stay healthy?" and "Why do people find themselves in the positive end of the good health—bad health continuum?" Antonovsky's (1987) research provides an answer to these questions, the Sense of Coherence (SOC). In this study, however, I returned to Antonovsky's original questions and focused on job engagement, assuming it to be an essential factor in explaining how nurses stay healthy despite the adversities of the nursing profession. Having said this, I was able to recognize elements in the data that appeared to be compatible with a sense of coherence perspective; however, due to an unstructured use of the SOC construct in this study, these findings do not provide new knowledge concerning the SOC.

6.2.1 Sense of calling

When the subject of 'calling' arose during the interviews, the nurses talked about their core values, they reported that they experienced meaningfulness when important values were expressed through their work. Apart from one nurse who described calling in religious terms, the nurses described calling in terms of being driven, of having a mission in life, of contributing positively to other people's lives, of being of service, of being in the right place, in the right position, and of having special goals to fulfil and of having a special task to attend to. These nurses emphasized that, for them, 'calling' had nothing to do with religion, saying that the automatic association of the term 'calling' to religion made them sceptical of the term, and that they were more comfortable using the above phrases. In searching for an appropriate expression that conveyed the various ways in which the nurses expressed themselves concerning calling, 'sense of calling' seemed to be the most suitable.

The nurse who spoke about calling in religious terms described her experience of being led to nursing by God and her feeling of being in the right place.[7] The descriptions of the remaining

[7] Almost two thirds of the students enrolled in nursing courses in a private, faith-based university who were interviewed in a study by Prater and McEwen (2006), reported that God had called them to nursing.

nurses may be understood more in light of the argument made by Dawson (2005), that in the 20th century, the meaning of calling (or vocation in Dawson's words), is a reflection of the search for meaning and purpose in life. It is, however, also interesting to interpret the findings in view of the third position outlined by Martinsen (2001, 87); 3), in which calling to a life of charity has a law-like character—essential and fundamentally human.

If the sense of calling were understood as argued by Martinsen, then it may be suggested that a sense of calling is compatible with good health, and that it would be wise to listen to, and follow it. Further, it may even be health promoting, and to not allow for its expression may have an adverse effect on health. The nurses in this study showed that they had the capacity and willingness to listen to and follow their sense of calling. In doing so, I propose that they initiated a health promoting process. At the same time, however, the findings of my study suggest, that a sense of calling may also actually lead to loss of job engagement. This may be due to the high ethical standards, feelings of duty and demands of self and of others that seemingly lie inherent in the sense of calling, or at least appear to be awakened when the possibility of living the sense of calling is realised through work.

Using the concept of calling may make it difficult to communicate the findings of my study due to the religious connotations of the term. Further, despite tendencies today to revive positive elements of the idea of calling in nursing and in other professions, calling also seems to be associated with words that have negative connotations such as self-extinction, self-sacrifice, obedience and subservience, all of which are in contradiction with the idea of professionalism and of paid work (Martinsen, 2001). Moreover, working conditions for nurses continue to be the subject of debate regarding the adequacy of wages, equity concerning gender and a heavy work load. Nursing, seen as a calling on one hand and a profession on the other, is therefore in a state of tension. If the study was presented as having, in part, to do with calling, the above associations may be the first ones that come to mind. The term 'sense of calling', however, seems better able to communicate the essence of the ideas expressed by the nurses, although for many readers the subtle difference may go unnoticed.

6.2.2 Calling/vocation match

As discussed above, one of the nurses reported her being called to nursing in religious terms, while the remaining nurses talked of being called in secular terms. One may speculate as to whether being called to nursing by God will result in an even more intense awareness of calling that may lead to a stronger drive to remain in nursing despite difficult working conditions. Although some might experience being called by God as a burden, others may experience it as the greatest joy to be called to fulfil the wishes of God on earth. This may mean that the experience of calling as something religious may intensify the pathogenic process whether or not the calling is experienced as a burden or as a joy. Nurses who feel called to their profession by God might reflect more consciously and piously on their call, and therefore endure the effects of the pathogenic process even to the extent that they lead to fatigue and burnout.

The remaining ten nurses in this study who felt a sense of calling to nursing reported that their sense of calling was not something they dwelt upon on a daily basis. Despite this, however, they expressed a high degree of ethical awareness, and of having been called by values that were important to them. When their working conditions changed in adverse ways, these nurses sensed that they were unable to continue their work in accordance with their core values. It might be the case, however, that a secular sense of calling, if less intense than religious calling, may enable an earlier initiation of active coping, that may even lead nurses to leave nursing all together if working conditions are experienced as too harsh. This does not rule out the possibility that nurses who do not feel called by God, may experience the ideology of nursing to be so binding that they choose to continue working when the conditions they work under deteriorate, due to a strong feeling of duty towards their patients and colleagues.

From this line of reasoning, it may be suggested that the pathogenic process becomes intensified when nurses choose nursing on the basis of their religious convictions. Further, this may also be the case when a nurse, regardless of her religious convictions, feels a strong sense of duty towards her patients and colleagues, or feels restricted by a lack of opportunity to seek a new position or to find a new workplace.

6.2.3 Job engagement, meaning, zest for work, vitality

The initial element in the salutogenic process, the calling/vocation match, and also its prerequisite, a sense of calling, has been addressed above. The calling/vocation match promotes job engagement, which in turn promotes meaning, zest for work and vitality. Job engagement, meaning, zest for work and vitality will be discussed below.

In this study, job engagement is described as an ongoing process more than a state. Job engagement is part of a larger picture that not only involves meaning, zest for work and vitality, but also a sense of duty, moral distress, overload, fatigue and burnout. Further, job engagement is initiated by, and has its roots in, a sense of calling, and in the case of the nurses in this study, the calling/vocation match. Thus, job engagement differs in this sense from Schaufeli and colleagues' (2001, 74), description of job engagement as a *"positive, fulfilling, work-related state of mind that is characterized by vigor, dedication and absorption…"*. As outlined in this dissertation, job engagement also differs from their definition in regard to the importance of meaning and meaningfulness, which was strikingly apparent in this study. A re-conceptualisation of the construct of job engagement is, therefore, suggested. The short version would be:

Searching for meaningfulness → experiencing meaningfulness → holding on to meaning

Making the concept of meaning central to the construct of job engagement, as I do here, does not displace the concepts of calling, zest and vitality. On the contrary, consideration of the meaningfulness concept helps to place calling, zest and vitality in a sequence-like relationship to one another, as illustrated below:

> Existential curiosity/awareness of one's sense of calling (path to one's search for meaningfulness) → calling/vocation match → gives meaning to life/living one's values (experiencing meaningfulness) → meaning gives zest → and zest provides the vitality to be engaged even under difficult working conditions (holding on to meaning).

I propose, therefore, that job engagement is not merely a state of mind characterised by calling, zest and vitality. I suggest that job engagement is a process permeated with and driven by meaning. Further, job engagement can also lead to the opposite of what one associates with

job engagement, in the form of moral distress, overload, fatigue and exhaustion. Thus, meaning appears to guide both the salutogenic and the pathogenic processes. A sense of calling may be understood as a search for meaning. In the instant when calling and vocation match, one experiences the potential for meaning, and in job engagement, one experiences meaning in a concrete way, leading to zest for work and vitality, wherein vitality also provides the energy needed to hold on to meaning. Meaning appears to be enhanced in the salutogenic process, while in the pathogenic process, meaning seems to be threatened or weakened, leading one to strive towards keeping the experience of meaning strong. Dealing with the apparent paradoxical role of job engagement requires self-care, which allows for the holding onto meaning, zest and vitality, and functions as a buffer against burning out.

It is the ongoing experiencing of job engagement, which appears to involve the continual enhancement and maintenance of meaning that, I term salutogenic. One might say that the Model as a whole depicts the salutogenic process, suggesting that the salutogenic process includes both the mediating and the pathogenic processes in its active coping with the threat of burnout, and in its ongoing search for experiencing meaning, holding onto and enhancing of meaning. In proposing that the whole Model represents a salutogenic process, it takes into account Antonovsky's (1979) argument that stressors are omnipresent in life and that coping actively with them, (in this case, the threat of burnout) is paramount for moving towards the positive end of the good health-bad health continuum. In this study, that which threatens meaning and moves the nurse away from the experience of job engagement is termed the pathogenic process, discussed in 6.3. Further, the salutogenic process and meaning, zest for work and vitality can be stimulated and protected if the nurse engages in an ongoing mediating self-care process described as 'self-tuning', and which has as its fundament the talent and habits of introspection, sensibility, reflection and active coping, discussed in 6.4.

A few comments concerning zest for work are called for. In paper 1, zest for work was presented as a phenomenon consisting of four elements. While two of these elements; 'mastery, learning, personal and professional growth' and 'relationships with co-workers and leaders' are similar to other researcher's conceptualisations of zest for work (Sørensen, 2003; Velten, 2003), this study demonstrate a close association between zest for work and meaning. The nurses expressed the need to develop personally and professionally *because* they had meaningful tasks to attend to. This is in line with the ideas of Pines, who posited that

developing a sense of competence is important because it gives a sense of existential significance: “If my work makes a difference, I make a difference” (Pines, 1993, 36).

Further, concerning the nurses’ relationships with colleagues and supervisors, the nurses pointed out the importance of having a socially pleasant work-environment. However, they placed even more importance on the possibilities of having work-related discussions and receiving support concerning nursing practice. The nurses also emphasized that zest for work is heightened when they experience that co-workers believe in, and work for, the same values and goals as are important to them. The joint quest for meaning is, thus, more inspirational and joyful than the individual one. The findings in this study appear to support Sørensen (2003) and Spilling (1955) by suggesting that zest for work is considered by the nurses in this study to have value other than that of material gain.

The Self-tuning Model of Self-care has thus so far been discussed without reference to its possible limitations, in particular limitations regarding its transferability to helping professions other than nursing. These limitations will be addressed here. Many people (not only future nurses) may experience, early in life, a special interest in, or pull towards a certain line of work, a sense of calling that leads them to find a profession or job that matches their sense of calling. In this study, the profession concerned was nursing and the jobs were various positions in community health nursing. In paper 3 we raise the question, is nursing in some way unique with regard to sense of calling and fulfilment? If this is so, interest in this study may be more limited than we hope it would be. In paper 3, we suggest it is likely that many people in other helping professions may also have stories to tell that are similar to those told by the nurses in this study. There are, however, at least two reasons why this might not be the case.

First, it is certain that those who feel called to living a humanitarian life often find themselves working in helping professions as the result of some kind of ‘sorting mechanism’ over which they appear to have little or no control. By ‘sorting mechanism’ is meant the processes, forces and conditions of life that tend to steer people in one direction rather than in another. Societal forces in Norway, for example, have traditionally resulted in women being recruited to a career in nursing while men have become doctors, although this is changing. Female doctors and male nurses are, however, still an exception rather than a rule, and for them, the experience of job engagement, and of holding onto it, may be different to that experienced by

the nurses in this study. Nursing is characterised by high demand, low degree of control, low(er) reward working conditions, and intimate patient contact, while being a medical doctor is characterised by high demand, high degree of control, high(er) reward working conditions, and less intimate patient contact (at least in many cases). Without wanting to do doctors of either gender injustices, the status that society gives to doctors may make the drive for achievement of equal or greater importance than a sense of calling in the choice to be a doctor than it is in the choice to be a nurse. Personality characteristics and environmental factors may, therefore, play an important role in the experience of job engagement, which may be experienced differently by a female nurse as opposed to a female doctor.

Further, it is known that professional training may have a strong influence on the attitudes, values, beliefs and aspirations of students. A quick mental experiment illustrates why this may be important with regard to the transferability of the Model. First, let us assume that a young Norwegian woman and a young Russian woman who both feel called to aide the sick, decide to apply for training in a health profession. The Norwegian woman is likely to enter nursing school, where she is influenced by nursing traditions, nursing philosophy, ways of communicating, etc, while the Russian woman is likely to enter medical school (most Russian doctors are female), where she is influenced by medical traditions, etc. Thus, two young, socially-conscious women with humanitarian concerns (not very different?) graduate and find work in their respective professions. They may have been quite similar as adolescents, but their working environments and conditions are radically different, and their attitudes towards, and their values and beliefs concerning their jobs and their professional roles are also likely to differ. In other words, their experience of job engagement and of holding onto it may not be the same.

The same differences may also be found when looking at the professions of occupational therapy, physiotherapy, child welfare, teaching, pre-school teaching, and other professions to which nursing is perhaps more comparable, at least in regard to length of training. These professions may recruit students who feel called to living a humanitarian life not so different from the nurses in this study, yet who may experience job engagement differently. However, this should not be overstated. Although these professions provide services to people in different life situations than those who receive nursing care, they have more in common with the nursing profession in relation to working conditions, degree of control, demand for staff, rewards and challenges related to overload, fatigue and the threat of burnout than the medical

profession has. Hence, it is reasonable to suppose that people in these professions would identify with the stories told by the nurses in this study.

Another troubling factor that may limit the generalizability of the Model lies in the nurses' stories themselves, and concerns the particular way in which nurses articulate themselves as opposed to the articulation style of other helping professions. The words, phrases, concepts and feelings expressed by the nurses in my study may, in some way, have been shaped by nursing training and practice, resulting in a 'nurse's way' of telling stories that differs perhaps, from a 'physiotherapist's way' or a 'teacher's way' of telling stories. As the analyses in this study and the Model they generated are based on stories told by nurses, and also on a nurse's interpretation of them, one wonders whether the story of job engagement would be the same in a study that looked at another helping profession.

This would be of little interest or concern, were the Model meant to be only a frame for communicating the present study's results to readers. Indeed, when my co-author and I started constructing the Model, its only purpose was to assist us in making sense of the data, and of my interpretation. In other words, the Model served as a tool for us and us alone. However, it quickly became more than that, and we could not help but wonder whether we had stumbled onto something important, something worthy of dwelling on and pursuing in a scholarly way. We were not so bold as to claim to be developing theory from data, but a theory (with a little 't') seemed to be emerging. If new knowledge is not pursued, theory will not be developed, but if we go on to study job engagement in helping professions that are distinct from nursing, we might discover the extent to which the main processes of the Model are supported by further research. Following this study, therefore, our main priority is to conduct a new study, with a study design very carefully thought out. We will need to maximise the similarity of the new interviewees to the nurses in this study with regard to sense of calling, and maximise the dissimilarities of their working environments and working conditions (e.g., demand, control, reward, etc). This study, however, has not yet been planned in detail.

6.3 The Pathogenic Process

It seems to be a paradox that job engagement can contribute to poor functioning. One explanation, offered in paper 2, suggests that, while striving for meaning underlies job engagement, it also underlies a strong sense of duty, and can lead to moral distress, overload,

fatigue and burnout when resources are exceeded by self-demands. The paradox seems to have its roots in the sense of calling and in the calling/vocation match, both of which are the key factor in two processes that simultaneously lead to high job engagement and to highly diligent dutifulness. The nurses' devotion to work fostered a strong sense of duty and of responsibility—self-responsibility and responsibility for others—and led to a work ethic that called for continuous improvement and constant striving for excellence in themselves and also wanting excellence in others.

In this study, the nurses' strong sense of duty and responsibility reportedly led to moral distress and overload. Thus, the calling/vocation match not only led to job engagement, but also triggered a pathogenic process that led to psychological vulnerability, and for some of the nurses, to fatigue and for one, even to burnout. In the Model, this is depicted as a pathogenic process, inhibiting movement towards good health on the good health – bad health continuum.

6.3.1 Duty, moral distress, overload, fatigue and burnout

As described in paper 1, the nurses appeared to be very conscientious people. They also seemed to live their lives according to high ethical standards that found expression through their work. Finding meaning in their work was closely coupled with the need to live up to high performance standards, and to the opportunities that nursing gave them of living out their deeply-held values. At the same time, the nurses were strict when evaluating their own work performance, and that of their colleagues. If they were unable to rely on their co-workers to do their work 'the right way at the right time', they often chose to do the work themselves. This seemed to lead them into the trap of heavy duty. If the quality of the work performed by others did not measure up to the nurses' personal and professional values, and they let it pass, it may have resulted in moral distress. On the other hand, overload may have occurred when the nurses chose to do the work themselves in order to maintain the high standard of quality they had set for themselves. This pattern is similar in several ways to Hallsten's (1993) idea of 'absorbing commitment' which will be discussed below.

The calling/vocation match seems to promote absorption in one's work. According to Hallsten (1993), 'absorbing commitment' may heighten the risk of burning out, depending on a person's level of vulnerability. The degree of a person's vulnerability is thought to be dependent on several factors (1993, 101): "1) the instability of self-image and self-esteem, 2)

the degree of dependence on self-definitional role enactment and the lack of subsidiary or potential roles for self-definition, and 3) the degree of social support outside the present work domain." The accounts of the nurses in this study included many references to the importance of engaging in activities outside of nursing. None of the nurses reported that nursing was their sole "self-defining role". Hallsten (1993) claims that the lack of social support is probably the most important factor contributing to vulnerability. The nurses in this study described having family and friends both at work and outside work, in whom they could, and did confide. This helped them to vent their personal and work-related emotional issues. Although the data material did not provide information concerning the stability/instability of self-image and self-esteem, the nurses appeared to display a low degree of vulnerability in relation to Hallsten's (1993) definition. Engaging in activities outside of work and solving emotional problems are two of six active coping strategies that came to light in this study (the remaining four are discussed later in this section).

Besides vulnerability, Hallsten (1993) suggests two key contributing factors to the process of burning out; 'goal orientation' and 'an incongruous environment'. High vulnerability, combined with high goal orientation and perceived incongruity between one's own goals and that of the work place, have the potential to foster absorbing commitment, frustrated strivings and the threat of burning out. The nurses in this study had a high goal orientation. They also enjoyed a good match between calling and vocation, and a high goal congruency between their own goals and values and those of their workplace. However, vulnerability was also a part of their personal work experience, due to a strong sense of duty and strict self-demands and high performance standards, in relation to wanting to deliver quality patient care despite the adversity of community nursing (as described earlier). The nurses' initial high goal congruency may, therefore, have been reduced because they were dissatisfied with the quality of patient care they were able to offer. Low goal congruency, in turn, seems to have led to moral distress, overload, fatigue and the threat of burnout.

The Model's pathogenic process is thus understood as an ongoing process of evaluation of the current possibilities to express deeply held values through nursing practice. The nurses tried to maintain a high level of congruence between their own values and goals and those of their workplace, by making high demands of themselves and of their co-workers. In the Model, this pathogenic process is not intended to be entirely, or even mostly, depicted as an overt

cognitive evaluation, but consists of a blend of introspection, sensibility and reflection, in which sensibility is the constant (pre-cognitive) element.

When goal congruency was weakened, the nurses had learnt by their earlier experiences not to respond to this negative process by closing their eyes. Their self-care resulted in flexible and active coping. They took deep stock of the situation and made the changes necessary to strengthen the meaningfulness of their work, either by making adjustment to the calling/vocation match, or by adjusting their perceptions of self, their colleagues and/or their environment. In some instances, both types of adjustments were made.

The question of the possible uniqueness of the calling/vocation match to the nursing profession has been discussed above. To respond to the pathogenic process the way these nurses do, it appears that one needs to be aware of the fact that incongruence between personal values and goals and those of the workplace is the source of distress. We suggest in paper 1, that the practice of introspection and reflection can be activated, or at least 'tuned up', by near burnout experiences. The ability to cope with this type of distress may be a result of personal experience with near burnout and not the result of the nature of nursing as a profession. By studying persons from a variety of professions who have experienced burnout and who have regained job engagement, it may be possible to learn more about the pathogenic process and the self-care needed to gain strength and well-being in relation to work and to life.

6.4 The Mediating Process

The mediating process is in this study described as an ongoing sensing/reacting self-care process termed 'self-tuning'. The mediating process is characterized by the nurses' ability to pause, to concentrate inwardly and to reflect on their own situation. Through doing this, they appear to monitor their personal and environmental states and the degree to which their situation allows them to express core values through work. Thus, they seem to self-tune by using their capacity for introspection, sensibility and reflection to continuously evaluate their job situation and to make necessary changes to ensure or re-establish congruence between calling and work. In this way, the nurses attempt to protect meaning, zest for work and vitality in an ongoing process.

6.4.1 Introspection, sensibility and reflection

Sensibility, presented in paper 3 as a pre-cognitive apprehension of one's inner state, is the most intuitive element of the Model. In paper 3, we raise the question as to whether sensibility can be learnt. If sensibility can not be learnt, then self-care, as it is understood in this study, may not be teachable and this would limit the generalizability of the findings to a considerable degree. Therefore, the sensibility construct plays a central role in the Model, and requires careful consideration.

One philosophical question that is important to ask is whether it is possible for a human attribute to position itself beyond the reach of reflection (Skjervheim, 1996). When considering my data early in the study, I wondered what it was that awakened the nurses to the thought of engaging in self-care, and what it was that made them aware of the need for change in order to protect their job engagement. Nortvedt and Grimen (2004) address the very same issue, when they argue that in exploring the conditions of reflection, one will inevitably reach the understanding that reflection no longer creates itself, but is awakened by something beyond itself which it has not created. While reflection and interpretation require active consciousness, sensibility is understood to be a form of consciousness that is passive and unprepared (Nortvedt & Grimen, 2004, 41-42). In order to illustrate this Nortvedt and Grimen use a patient's pain as an example: the pain 'hits' the helper at an intuitive and impression-based level, this is a moment of non-intentional interpretation, it is a special moment of passive receptiveness that is essential in understanding the reality of clinical health care. When the nurses in this study talk about how they listen to internal signals, I feel they are describing moments of passive receptiveness. The nurses' carefulness in not (once again) crossing the line of fatigue and burnout symptoms seems, therefore, to be governed by the limits set by their bodies and feelings. The perception of these signals appears to be immediate and affective. The signals are there to be captured. What the nurses choose to do on the basis of them is a question of intention, reflection and interpretation. Sensibility represents, therefore, a vital part of the nurses' self-communication, in which the signals from self are captured and made the object of reflection.

Furthermore, Nortvedt and Grimen (2004) claim that sensibility, in its receptiveness towards the expressions of others, also encompasses a moral dimension that involves responding ethically to these expressions. This argument is also put forward by Martinsen (2001), who suggests that being 'sensible' to the patient's experiences of illness and of health is to see with

the eye of the heart. In line with the above positions, I raise the question: might it be possible, that through the receptiveness of one's own vulnerability, an impulse, a wish or a sense of ethical responsibility may be awakened that calls for the taking care of one's own health? In moving from sensibility to reflection there is, of course, the possibility of ignoring signals and of suppressing vulnerability. The nurses in this study, however, told that they had learnt to listen to the signals they received, and they demonstrated a readiness and willingness to act upon them.

Nortvedt and Grimen (2004) present the construct of sensibility as being a capacity desirable for people in the helping professions to develop, in order to sense and understand the experience of being a patient. I argue that the nurses in this study serve as a practical example of the way in which sensibility can be used in relation to one's self, as part of one's self-care. The ability of these nurses to do so may have been enhanced by nurse training and practice, although the data material did not allow for the exploration of this possibility. What is important, however, is to consider the use of sensibility as a central feature of caring, directed towards both patients and professionals. In order to provide quality nursing care it is important for nurses to be engaged in their work and to stay healthy. Nortvedt and Grimen (2004) argue that sensibility is essential for the provision of quality patient care, and while I agree with their argument, I suggest further that sensibility is also essential for job engagement and for the health of those providing care.

The sensibility element is therefore vital to the mediating process, and begs the question, can sensibility be learnt? I will address this question after having discussed 'active coping' in the mediating process.

6.4.2 Active coping

As presented in the three papers, the nurses in this study were adept at acting on the decisions they had made to protect job engagement. Active coping focused on one or both of the following: making changes in one's work situation, or finding a new job in order to regain an equilibrium between calling and vocation; and, adapting one's standards concerning what it means to provide quality care and to be a good member of the nursing team in relation to the giving and receiving of supervision, to a more realistic standard. This form of active coping may be contrasted to wishful thinking where one assesses the situation and considers changes

that are desirable, but action is not taken, or is simply denied. Hallsten (1993) and Maslach (2003) observed that denial and an intensified performance are coping strategies that people tend to use when threatened with the development of a burnout syndrome.

Unlike others, the nurses in this study had learnt not to deny their situation. They appeared to have a relatively clear understanding of their situation, and they acted in order to improve their situation when they judged it to be too harsh. The nurses' way of coping seems to include the three possible resistance responses summarised in Perlin and Schooler's (1978) classic trilogy: alter the problem directly; change one's way of viewing the problem; manage emotional distress aroused by the problem. Any or all of these strategies could be enacted, based on a range of decision-making approaches that may include a sudden flash of insight that leads to action, or well-thought out and carefully implemented action. The nurses' described active coping as a continuous evaluation of the environment, and as the understanding of self-in-the-environment, in other words, a conscious, deliberate strategy, that includes the essential, pre-cognitive element of sensibility. As mentioned earlier, sensibility may be the Achilles Heel of the mediating process, if it can not be taught or learnt. If this is the case, the Model is only descriptive of a limited range of possibilities regarding holding onto job engagement in the face of adversity, and its utility will, therefore, be rather limited. I will now discuss this issue, stating at the outset that from my own experience as a nurse educator, sensibility can, indeed, be taught and learnt.

The nurses in this study underlined the importance of 'accept' in their self-care. Carl Rogers claimed: *"It is a weird paradox that in accepting myself as I am, I can change"* (in de Vibe, 2006, 3). The idea of 'accept' and 'accepting' is an important aspect of my approach when teaching self-care to students in health promotion. My experience, so far, shows that working with the concepts of 'accept' and 'accepting' appear to release energy and vitality. These concepts seem to increase awareness and sensibility of signals from body, feelings, mind, environment and existential depths, and allowing for the making of changes and for engaging in the promotion of health. Furthermore, the stories told by the nurses in this study illustrate the importance of the acceptance of one self and others as a key factor in active coping, while 'accept' appears to be the key to enhancing one's own sensibility.

The findings of this study show that vulnerability is also an important aspect of active coping. Interestingly enough, vulnerability was not only found to be something negative, but it also

appeared to have been advantageous for the nurses. Although vulnerable, and in moral distress, at earlier points in their careers, the nurses reported a high degree of job engagement and seemed to be thriving at the time of the interviews. My own experience from teaching self-care is that activating and developing introspection, sensibility and reflection involves being vulnerable, in the sense of opening up to life and to becoming aware of feelings, bodily sensations, relationships, patterns of thought and signals from existential depths. In some cases this may open up previous life experiences that reactivate feelings that increase the experience of being vulnerable. According to the nurses' stories, the process of 'becoming aware' helps one to become increasingly more in tune with one's self, and thereby facilitating greater congruence between the sense of calling and vocation. Although it might sound strange, vulnerability may actually be a characteristic of a person with a strong sense of job engagement, and therefore it may be health promoting.

6.5 Limitations and methodological issues

Important limitations in this study have been discussed above, and also addressed in the three papers. Limitations and methodological issues that deserve additional discussion concern the study's sample, and the positioning of the study between the ideal of phenomenological openness and hermeneutical reflective interpretation.

The validity of the argument that job engagement not only leads to the capacity to function well, but can also lead to poor functioning rests on the quality of the study as a whole. In addressing the validity of this argument, it is necessary to say a few words about the study's sample. The method of sampling employed, excluded nurses who cope with the threat of burnout and the symptoms of burnout by leaving the nursing profession, and whose experience of stress may be different from the accounts given by the nurses in this study. In this study I have interviewed only 'successful' nurses who retained job engagement despite harsh times and near burnout. Importantly, some nurses are not able to change their job, to alter their working conditions, or to leave the workforce, and they must continue to work despite symptoms of burnout. Yet others struggle with the same issues as the nurses in this study did, and resolve their difficult situations by leaving nursing. This could, however, be the result of successful coping, albeit of a kind different than described in this dissertation. Two of the nurses interviewed in this study explained that nursing was but one of several possibilities of finding meaningful work. In a sense, their values were larger and more

important than their choice of profession. Thus, leaving nursing and finding other employment may be the result of successful self-care. Of course, it may be that nurses who deal with stress by leaving the profession are less wedded to nursing as a way of living a meaningful life. The level of fatigue that nurses experience due to moral distress may vary with the level of commitment to nursing as a sense of calling. Incongruence between the values that one holds dear both personally and professionally and one's work situation may have increased the moral distress of the nurses in this study compared to nurses for whom nursing is more an occupation than a vocation. That the nurses in this study appeared to consider nursing to be more a vocation than an occupation may explain their efforts to keep on performing, despite symptoms of exhaustion and burnout, and to develop self-care strategies to cope with the threat of burnout. Either way, the inclusion of nurses in a future study sample, who resolve the threat of near burnout by leaving the nursing profession, is important in order to further explore the maintaining of job engagement in the face of adversity.

Finally, regarding the study's position between the ideal of phenomenological openness and hermeneutical reflective interpretation, it is important to consider whether the degree of openness that is both appropriate and necessary has been obtained. Have I managed to be sufficiently true to the life-worlds of the nurses? Did I turn to the 'things themselves', and have I been adequately sensitive and faithful to them? Based on my own pre-understanding and theoretical perspectives, I chose to structure the interviews around the phenomena of calling, zest for work and vitality. This may have influenced the nurses' responses to the extent that important aspects of job engagement were not revealed. However, according to the hermeneutical tradition and the epistemological stand taken in this study, knowledge is limited and is dependent upon the context in which it has emerged. As one can always move and extend one's horizon of understanding, knowledge is ever changing. In this dissertation, I have endeavoured, to the best of my ability, to account for my own pre-understanding and theoretical perspectives. Other researchers may choose to investigate job engagement from the same theoretical perspectives that I had, or they may choose to use a different theoretical approach. Each approach will, however, contribute to the generation of new knowledge concerning job engagement.

6.6 Implications of findings and suggestions for future research

The findings of this study suggest that to promote job engagement, acknowledgment of the importance of values and value conflict is vital both before a choice of profession is made and on a relatively continuing basis during one's work life. This brings interesting perspectives to vocational guidance. Feeling that one has failed at finding meaning and existential significance through work is a risk factor for burnout (Pines, 1993). In light of recent statistics showing that increasingly younger persons are at risk of burning out, the question arises as to whether the process of burning out is not necessarily rooted in an initial state characterised by high job engagement and high emotional involvement in work. It may also be the case that if one fails to dwell on the meaning of life, one's values will not crystallise sufficiently so that work becomes a vocation. Vocational guidance counsellors, for example, might consider stimulating the quality of introspection undertaken by their clients, so as to increase their awareness of the values that are important to them, and also to stimulate the capacity for self-care that is necessary in order to deal effectively with adverse effects that may arise from a good calling/vocation match.

Several lines of research are suggested by the findings. Perhaps, most importantly, the possible effect that the setting in which my study was conducted may have on the findings, needs further investigation. There may be some features of life in Norway, or of nurse selection, nurse training or management, or of the health care system that account for the main finding, that job engagement has a paradoxical role in nurse work-life and can lead to burnout. Research along the same lines, but in different settings is called for, in order to illuminate this more. I also suggest that the validity of the arguments made in this study requires investigation, by studying nurses who cope with adverse conditions by leaving nursing. Are there other critical factors than those I have observed, which differentiate between those who stay in nursing and those who leave, or are the differences more circumstantial, due, for example, to the relative presence or absence of opportunities for change? Norwegian communities tend to be small, with populations numbering in the hundreds and in the low thousands. The largest community of people in the country is found in the capital, Oslo, with a population of 544.000, more a large village in comparison with the major cities of the world. It may be that coping with adversity by leaving one's job or profession is the most common way to cope when opportunities for change are plentiful, as may be more the case in large cities with more extensive health care workforces.

Current research on moral distress and burnout focuses primarily on the distress resulting when one knows the right thing to do in a given situation, but institutional and organizational constraints make it difficult to follow the perceived right course of action. Some nursing research suggests that 'the right thing to do' is coupled with values inherent in nursing philosophy (Nordam, Torjuul, & Sørlie, 2005; Radziewicz, 2001; Severinsson & Hummelvoll, 2001; Sundin-Huard & Fahy, 1999). The findings of this study also appear to support this view. Further, this study suggests that for some nurses, 'the right thing to do' may be inextricably linked to personally held core values. On the basis of these findings, more research is called for, with diverse samples of nurses, to explore systematically the interrelationships between personally held core values and vocational values on the one hand, and moral distress, burnout and coping on the other.

The nurses in this study had a talent for and the habit of, engaging in self-care—a salutogenic process involving introspection, sensibility, reflection and active coping. They wished to understand self and others, and they paused, concentrated inwardly and reflected upon their own situation and inner state, and they made room for spending time in silence and withdrawn peace. Introspection is a key – silence, it seems, is a necessity. Martinsen (2001) argues that silence is essential for understanding others. She claims that in silence, it is possible to open up to the world, to see, hear, smell, and touch with mindfulness and in patience: to be aware and to fully assess the moment. This seems to be a vital aspect of self-care as described by the nurses' in this study. An intriguing question remains to be answered: are there any links between the nurses' self-care and the quality of patient care? My assumption is that sensibility directed towards the nurse's self, in his/her self-care, may be a precondition for, and enhance the quality of patient care that Martinsen (2001) and Nortvedt and Grimen (2004) call for. This, however, needs to be investigated further.

Further, the nurses demonstrated the ability to carry out the changes that they had decided upon. This stands in contrast to wishful thinking, whereby one may consider one's situation, realize the need for change, and assess possible solutions, but do not act. An in-depth exploration of the characteristics that underlie a 'willingness to act followed by action' is called for. Knowledge about this matter would be considered to be very valuable from a health promotion perspective. While health promotion is complex and involves initiatives on political and structural levels, as well as at the group and individual levels, it can not be

accomplished on the individual level alone. The present findings, however, do call for further investigation at the individual level in order to explore the issues raised above.

Finally, there is the question of whether nurses' skills of introspection, sensibility and reflection can be more finely developed during training and afterwards, enabling them to be more aware of the tendency to burn out, and to engage in active coping early in the process should this occur. This calls for intervention research, alongside the explorative and descriptive research mentioned above. I argue that the findings in this study bring with them an obligation to consider the inclusion of the systematic teaching of self-care for nurses in the nursing curriculum, and perhaps also include the teaching of self-care in the curriculum of other helping professions. Knowing the risks of moral distress, overload, fatigue and even burnout that these professions carry with them, a systematic and extensive focus on developing job engagement and the capacity for active coping is paramount.

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Paper I

Community nurses who thrive: The critical role of job engagement in the face of adversity

Community Nurses who Thrive: The Critical Role of Job Engagement in the Face of Adversity (in press). *Journal for Nurses in Staff Development*

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Hege Forbech Vinje* CNS, RN
Assistant Professor

Vestfold University College
Faculty of Health Science
P.O. Box 2243
3103 Tønsberg
Norway
e-mail: hege.f.vinje@hive.no

Maurice Mittelmark, PhD, MA, BS, FACE
Professor

Research Centre for Health Promotion
Department of Education and Health Promotion
University of Bergen
Christies gate 13
5015 Bergen
Norway

Abstract

Among community health nurses who thrive despite difficult working circumstances, habitual introspection and reflection about job engagement helped them make positive, adaptive adjustments in their working life. A practical implication is the need to educate nurses about the importance of reflection not only over nursing practice but also of habitual introspection and reflection about their job engagement. Nurses in staff development should teach and reinforce the needed skills and habits.

Abstract only. Full-text not available due to publisher restrictions.

Paper II

Job engagement's paradoxical role in nurse burnout

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Abstract

Interviews were undertaken with 11 community health nurses and qualitative analysis sought to illuminate the ways in which job engagement was connected to their health and functioning. High job engagement followed from the nurses' deep feeling of calling to the nursing profession and contributed to a strong sense of duty and strict self-demand regarding one's own and other's levels of performance. In nine cases, perceived failures to live up to their own performance demands contributed to the nurses' near-burnout. This triggered extensive introspection and reflection, leading to positive coping and avoidance of burnout. The nurses coped by using their well-honed skills in introspection and reflection, which they had practiced habitually all their careers, to help them determine which personal and professional changes were required to maintain job engagement and satisfaction. Paradoxically, job engagement can not only promote thriving on the job, but also contribute to negative processes leading to poor functioning.

Key words

burnout, community nurses, job engagement, Norway, qualitative content analysis.

Paper III

Deflecting the path to burn-out among community health nurses: How the effective practice of self-tuning renews job engagement

F E A T U R E

Hege Forbech Vinje

Assistant Professor, Vestfold University College, Norway

Maurice B. Mittelmark

Professor, Research Centre for Health Promotion, University of Bergen, Norway

Deflecting the Path to Burn-out among Community Health Nurses: How the Effective Practice of Self-Tuning Renews Job Engagement

Key words: self-care; job engagement; burn-out; salutogenesis; nurses; qualitative content analysis

A B S T R A C T

Interviews with eleven community nurses with reputations for high job engagement revealed that nine had earlier been near burn-out but had managed to recapture job engagement. For these nine nurses, the path to burn-out was set by perfectionism and devotion to nursing as a calling, coupled with inability to meet arduous self-standards. The nurses' desire to regain job engagement triggered deep introspection and reflection, which in turn enabled coping, including solving emotional problems, striving to be a realistic idealist, making changes in the work situation and preserving time for contemplation. These processes underpin the Self Tuning Model, presented for the first time in this paper. This study suggests that the self-tuning exhibited by these nurses is salutogenic, supporting mental health and recapture of job engagement. Teaching self-tuning skills to people in stressful professions may provide skills that are critical to recapturing job engagement that may fade over time because of unremitting professional strain.

Introduction

The term 'burn-out' refers to the state of being unable to carry on in stressful work, because of changes in attitudes, behaviours and emotional condition among people who experience long-term imbalance between job demands and the resources needed to meet them (Halbesleben & Buckley, 2004; Maslach, 2003; Schaufeli & Buunk, 1996). Emotional exhaustion and a state of fatigue are core features of burn-out, and the terms emotional exhaustion and burn-out are often used synonymously (Matthiesen, 2002). The burn-out phenomenon is referred to above as a state. It can also be referred to as the end result of the process of burning out. Considered in this way, the process leading to burn-out is one in which the worker moves from feelings of involvement, devotion and desire for accomplishment, to feelings of disillusionment and a depression-like condition (Hallsten, 1993; Pines, 1993). It follows that a worker can move towards or away from burn-out. A person who feels near the state of burn-out can be said to be near burn-out, but the process need not end in disability. Reorientation or personal restructuring can restore functioning and help move the worker away from burn-out (Hallsten, 1993). The move away from burn-out is the subject of this paper, which describes self-care and recovery processes among nine community nurses who had burn-out, or near burn-out, experiences.

The term 'job engagement' has been defined as a:

> *positive, fulfilling, work-related state of mind that is characterized by vigor, dedication and absorption* (Schaufeli *et al*, 2001).

Job engagement is thus considered to be the positive antithesis of burn-out, characterised by a state of energy rather than exhaustion, involvement rather than cynicism, and efficacy rather than inefficacy (Maslach, 2003; Maslach & Leiter, 1997). A previous report described how the nurses experienced the nursing profession as their calling, providing them with the opportunity to 'live' their values, giving meaning to life even under quite difficult working conditions, all promoting job engagement (Vinje & Mittelmark, 2006a). We have also reported how their job engagement triggered a pathogenic-like process, in which their high standards led them towards exhaustion (Vinje & Mittelmark, 2006b). Interestingly, when they were recruited to participate in our research, the nurses were selected because they had reputations as well-functioning, vital professionals. Our original aim was to document the factors that contributed to their success. We did not know at the time of recruitment that nine of the eleven nurses in the original sample had experienced burn-out or near burn-out earlier in their careers. It was only during the in-depth interviews that we discovered their histories of burn-out and recovery, and extended the interviews to include their self-care experiences, providing the data for this report.

Self-care

Self-care is:

> *the voluntary regulation of one's own human functioning and development that is necessary for individuals to maintain life, health and well-being* (Orem, 1995 p95).

Although self-care is by definition an intra-personal phenomenon, families and communities have the capacity to facilitate individuals' self-care and often take responsibility for caring for individuals who cannot engage in adequate self-care (McCormack, 2003). Self-care, together with the support received from others to enhance its quality, contributes to optimal functioning, development, health and well-being. Self-care is, in other words, a protective factor and a fundamental activity. Self-care behaviours can range from actions taken to ensure survival, to activities that promote self-actualisation. The meta construct self-care has been refined by attention to four characteristics which seem to be central (Gantz, 1990 p2). Self-care:

- is situation- and culture-specific
- involves the capacity to act and to make choices
- is influenced by knowledge, skills, values, motivation, locus of control and self-efficacy
- focuses on aspects of health under individual control, rather than control by others.

Self-care has been the subject of research in diverse health specialities including medicine, nursing, psychology, health education, medical sociology and public health. As characterised by Gantz (1990), psychology is mostly concerned indirectly with the study of self-care, and not as an explicit phenomenon. Sociology's attention extends to the interrelationship of individual, group and community systems. In public health, self-care is seen as having mostly to do with engaging in health-promoting behaviours such as managing weight and exercising regularly. Self-care in medicine focuses mainly on transferring responsibility for the assessment of one's health situation from health professional to patient.

In contrast, in nursing science and practice, the self-care construct is concerned with individual uniqueness in coping style, communication pattern and learning style (Gantz, 1990), and it is in this sense that the term self-care is used in this report. For decades, discourse on nurse self-care that enables the best possible patient care has had an important place in the nursing literature (Orem, 1971, 1995, 2001; Orem *et al*, 2003). The fundamental tenet of the discourse is the importance of human beings' own resources for problem-solving and enhancing personal growth and development (Orem, 2001). The key resources are well-tuned perception and awareness, the ability to assess and judge the current situation, and the ability to choose, initiate and carry out appropriate purposive actions. In nursing, self-care is conceived of as nurturing the whole person: the body, mind, emotions, spirit and soul (Burkhardt & Nagai-Jacobson, 2001). From this holistic perspective, motivation for and skill in self-care are linked inextricably to one's curiosity about life and the search for meaningfulness (Dimitrov, 2003; Ventegodt *et al*, 2003).

While the nursing literature is rich with pronouncements about the importance of nurse self-care (Burkhardt & Nagai-Jacobson, 2001; Radziewicz, 2001; Riley, 2003), the research literature on self-care in nursing has to do with how nurses can teach patients to engage in self-care, not about how nurses themselves engage in self-care. Our literature search failed to uncover even a single study that focused on capturing the self-care stories of nurses who return to job engagement after burn-out or near burn-out. Yet these self-care stories were compelling in our study, and it seemed possible to extract from the data some understanding of the fundamental types of self-care that yielded positive results for the nurses. We therefore set out

to describe in this paper the self-care processes leading to the return to job engagement among the community nurses in this study. This should be of interest to all who work in the mental health promotion arena, since the problem of maintaining, or regaining, fading job engagement is relevant to all who work in demanding, stressful yet rewarding occupations. The intention is to contribute to knowledge about effective self-care practices for people exposed to unremitting professional strain.

Methods

The sample

The study used an explorative qualitative design in which data were collected through in-depth interviews (Denzin & Lincoln, 2000). Eleven Norwegian community nurses were nominated by their colleagues, because of their reputations for thriving on the job. In town A, three nominees from different wards were sampled from a nursing home, and two public health nurses in town A were added, using snowball sampling. Two participants in town B worked in two different nursing homes, and three others were employed in three different home care divisions operated by the municipal health service. The eleventh participant was recruited from a nursing home in nearby town C, using snowball sampling. Participants' ages ranged from 24 to 63 years, and years of work experience ranged from 1.5 to 41 years. This paper reports data from nine of the eleven participants, who reported having been at or near burn-out at an earlier point in their career. Each participant was briefed orally and in writing about:

- the study
- why and how she/he was recruited
- the time needed to participate
- the guarantee of confidentiality
- the right to withdraw from the study at any time.

The study was approved by the Norwegian Social Science Data Services (Ref. no. 9800).

Data collection

The data from the nine participants were collected in thirteen in-depth, one-to-one interviews. The interview and data analysis techniques combined a phenomenological approach (used to gather experiential information), and the hermeneutic technique (used to explore interpretative aspects of lived experience). The data analysis strategy was thus defined partly before the data were collected. However, the interview guide and the analytical tool were supplemented and developed during the course of data collection. The interviews took place from December 2001 to September 2004, in interviewees' workplaces or their homes, and lasted from forty-five minutes to two hours. The interview guide was modified from interview to interview, but the opening question was always 'Can you please tell your work-life story?'. Twelve interviews were transcribed verbatim by the first author, and the respondents read and approved the transcriptions. The thirteenth interview was recorded, but could not be transcribed due to an equipment failure. The data from this interview were recaptured as well as possible from notes taken by the researcher after the interview.

Qualitative content analysis

Qualitative content analysis was conducted with descriptive and interpretive approaches (Graneheim & Lundman, 2003). The analysis combined each participant's account and each issue and theme across participants, in a case-focused, cross-case and issue-focused analysis (Weiss, 1994). The analytical tool evolved throughout the project. Five analytical activities were undertaken. The transcripts were read through several times to obtain a sense of the whole, following which the material was divided into fragments of meaning. Through a process of transformation and meaning condensation, the fragments of meaning were examined to illuminate core meanings. Then a search for themes was undertaken – threads of meaning appearing repeatedly through the data (Graneheim & Lundman, 2003 p107). The analysis moved back and forth between steps and between cases.

Validity

We researchers engaged in formal reflective and systematic discussions, among ourselves and with colleagues in research seminars, concerning the interpretation of the data. The study, its methods and findings were also discussed with nurses and colleagues from other professions in lectures, workshops, seminars and conferences. These dialogues were undertaken in order to obtain as much interpretive insight as possible (Kvale, 1997; Van Manen, 1990).

Findings

The nurses' stories conveyed their strong sense of responsibility and duty. They said that they strove for

excellence in themselves and in others, and felt highly responsible for their own performance and that of fellow workers. However, this raised the risk of burn-out. The nurses described burn-out experiences of different lengths and intensity. Some of them just kept on working, while others took one or several periods of sick leave. One of the nurses was on full sick leave for six months, and worked only half time for a further six months.

The nurses described their self-care as holistic, both in the way they understood it and how they related to it.

> *'As human beings we are more complex than we often think; the spirit, body and soul are connected, and if anything happens to our body the mind is affected and vice versa, the whole life follows. We must pay attention to it all to stay strong and function well in our day-to-day living.'*

The nurses' self-care often combined actions.

> *'I often need to withdraw, to be by myself to examine and try to understand what's happening in me and around me.'*

Combined actions often played out in the following way. A nurse's abiding existential curiosity, about the surrounding world and about self, stimulated self-monitoring and self-tuning in her search for coherence. This led to decisions about actions she needed to take to protect coherence, and the nurses were adept at actually taking the actions that they had decided on. This contrasts with a type of wishful thinking in which all the steps mentioned above might be followed, but action would not be taken. Below, each of these phases, or aspects, of self-care is illustrated with the nurses' own expressions. We begin with the active coping strategies, because they provided the direct means to regain job engagement. This summary of findings ends with the nurses' descriptions of the precursors to action: existential curiosity, monitoring and self-tuning. However, ***Table 1***, below, presents a summary of the findings showing the functional order of self-care as revealed in these data to be existential curiosity ☆ monitoring and self-tuning ☆ active coping.

Active coping

The nurses described how they tried in various ways to ensure enough energy to keep on working with nursing, which gave life joy and meaning. They worked to stay in contact with those aspects of nursing to which they felt called, and which therefore motivated them. This self-care happened on both a philosophical level and a practical level. The data revealed six main active coping strategies, presented and illustrated below by the nurses' words.

TABLE 1 *Summary of Findings on Self-Care among Community Health Nurses who have Experienced Burn-out or Near Burn-out, but who Recaptured Job Engagement*

Introspection – sensibility – reflection: fundamental talents and habits reinforced by the features below

Existential curiosity	Monitoring and self-tuning	Active coping
■ Life is about learning, development and growth	■ Pause, implode and reflect on own condition	■ Striving to be a realistic idealist
■ Personal responsibility for being in a situation that is meaningful and joyful	■ The ability to know what is meaningful and the most important values	■ Engaging in meaningful activities alongside nursing
■ Personal responsibility for ensuring self-respect and self-appreciation	■ Finding the places and situations where these values are needed and can be expressed	■ Ensuring a place of silence and withdrawn peace
■ Purpose of work is to find the place to contribute to the best of ability	■ Searching for the best possible position	■ Solving emotional problems - moving on a continuum between involvement and detachment - finding own domain of control and responsibility and letting go of others' - ability to accept oneself and others
■ The need to understand oneself and others	■ To form and hold a visual image of the future which is actively present in the mind, not too concrete but open for adjustments	■ Accumulate learning from experience
	■ The will to choose it and the ability to make it happen	■ Ability and willingness to undertake major changes

Striving to be a realistic idealist

'I learned when I had this difficult time, when I was knocked over, that my idealism had to be balanced... I'm trying to be a tolerable realistic.'

The nurses said that their idealism about nursing had to be balanced with the facts of their working situation. They strove to adjust their vision of what was feasible and to recognise and respect the actual limitations in their situations.

'It is about being a bit more realistic. There are some limitations that I cannot remove by myself; I need to be honest and acknowledge the limiting factors or the prevailing conditions. Taking these things seriously doesn't have to mean I'm disillusioned. Maybe taking it seriously will give me the opportunity to do something about it. If one gets disillusioned, I think one has given up, I will never be disillusioned.'

Engaging in meaningful activities alongside nursing

The nurses described the need for hobbies and other activities alongside nursing, such as physical training, singing, painting, being with friends and travelling.

'I have a lot of hobbies really; it is about gaining energy... finding my own rooms... otherwise I wouldn't be this enthusiastic about work...'

The nurses expressed how the hobbies made them happy and full of energy.

'I really enjoy painting, it makes me very, very happy, and I can feel how much I need to have something else besides my job!'

Moreover, attending such activities seemed to help the nurses find solutions to troublesome thoughts.

'I'm singing in a choir, it is a giant battery-charger! If I'm a little bit worried and down before the rehearsal, it changes during the rehearsal, I just see things differently; I find a solution or see that it isn't so bad after all!'

Ensuring a place for silence and withdrawn peace

The nurses also expressed the need for balancing the sociable, extroverted activity of being a nurse with an introspective and withdrawn role, to recover and ensure vitality. The importance of silence and having 'room just for me' was underlined.

'I like being by myself, I just need it... it gives me what I would call life energy.'

Another participant expressed it like this.

'I really have a good time when I'm at home by myself without anything particular happening, when it is just quiet and calm. It is lovely, and if I have a day off I feel how I'm charging my batteries by just relaxing in my home, it is lovely.'

The nurses all acknowledged the importance of friends and social activities, but:

'the evenings when my children are asleep, and everything is calm – sometimes I turn off my phone and drive my car into the garage so that no-one can see that I'm at home (laughing) – yes, it is very important'.

Spending time alone in a sort of timeless space, withdrawing to nature, music, literature or just peace and calm were ways to ensure time for contemplation. One of the nurses put it like this.

'When I'm by myself and rather distant from the rest of the world and life in its fullness, when I'm allowed to be in peace, something odd happens... it is as though a whole new understanding of things permeates and pervades me, and that changes my way of being. It is very strange.'

Solving emotional problems

Solving emotional problems, whether caused by work or by personal matters, seemed also to be a critical part of self-care.

'I find being a nurse both emotionally and mentally challenging, and I must have the opportunity to process and let go of some of the things I carry inside. Not being able to process or let go of negative feelings will affect both the patients and me.'

In talking about solving emotional problems, the nurses expressed the importance of reflection – alone or with friends, family, colleagues, with nurse leaders or in nursing supervision groups[1].

[1]In Norwegian nursing practice, it is common for groups of nurses to meet as often as once a week, away from clinical spaces and duties, to participate in guided discussions about practice.

'Attending nursing supervision groups is very useful to reflect on issues I'm preoccupied with; talking about it helps me get rid of it. I feel that I take care of myself this way.'

In other cases, colleagues or nurse leaders were cited as important discussion partners.

'My immediate supervisor understands me very well; she has helped me recognise what I need to address, for instance letting people know when things are not OK, and I learn and develop with her help.'

It was important that emotional issues coming up at work were solved at work, preferably before going home.

'I used to talk to my husband about work all the time, he got so tired of it. Now I'm better at taking things up at work, where they belong.'

The nurses also expressed the need to have friends to go to with non-work-related emotional issues.

'I have a lot of friends and I always have someone to turn to with my troubles, so I'm rather good at giving vent to what's bothering me.'

Three emotional areas were described by the nurses as particularly challenging and in need of serious attention. One of these has to do with moving on the continuum between involvement and detachment.

'Instead of giving people responsibility and supporting them in their actions, we take over, and of course you will burn out because it is too much. We must find this limit, which is very difficult; I had to learn to say no, this is not my responsibility.'

The nurses expressed the importance of being near and listening to their patients, but at the same time of knowing the limits of involvement and responsibility. In processing emotional problems, it is important to be able to see the patient clearly and to know where the limit is.

'I believe being too involved is unprofessional and it is bad self-care. I think it is very important to know when to draw the line. But it is important that the patient doesn't experience the nurse as being detached.'

The nurses also reported that it could be difficult to keep to one's own responsibilities, and shed the habit of feeling responsible for others.

'The most important way I can care for me in all this, I actually think, is by giving myself some peace regarding what others do, letting them do and be where they are without my getting all stressed and worked up about it! It doesn't mean that I am not affected by other people's suffering; it means that I do not loose grip despite caring and participating in other people's challenges. It makes life much easier. I give others more space and I'm totally relaxed, so I let go of some of the strictness in me that needs to structure and control what people think, and it is OK. I think I've become a better nurse and leader because of this.'

Another nurse put it quite bluntly.

'I've had to lower my self-demands and also my expectations of others; being a leader, I have to put up with others not doing the job the way I would have.'

The third theme in the data to do with solving emotional problems related to how such problems could decrease their ability to produce qualitative care. They underlined that emotional problems made it difficult to be open and receptive, and thus interfered in getting to know, understand and accept patients, colleagues and themselves for what they are.

'I used to get so tired of other people's frustrations and shortcomings; eventually I understood that I had to change this. When returning to work after my leave of absence, it was almost as though I'd become more fond of people; it gave me a feeling of more richness in my relations; it is difficult to express; it is about giving people more space. I am more open, more humble, I can embrace people more fully, and accept that they don't always manage. This saves me from a lot of grief.'

Learning from experience, and ability and willingness to undertake major change

'One learns and sees things much earlier. I will recognise the warning signals very, very early, if there ever is a next time.'

The ability to move, to be flexible and to change their situation into a better one was evident in all the nurses' stories. One of the nurses recounted:

> *'I used not to pay much attention to my need to vent. I suppose I believed I was the strong one, managing everything, but I've learned, I learned from the period when I was so exhausted'.*

Another one described that she had learned to listen more carefully to herself.

> *'I learned that I have to listen to the signals I give myself. Before, I just kept on going, and I ended up totally exhausted. Later I understood that I had been driving myself too hard, so now I'm very much aware of taking care of me along the way.'*

Yet another participant described how she almost burned out about a year before the interview, and how at the time of the interview she still had to work hard to cope. She displayed awareness of what she had learned and what she needed to change.

> *'Instead of getting totally disabled – it was a period when I thought this could happen – I have tried to put the brakes on, and it is helping me, but I have to watch myself closely. At the moment I'm in this phase of letting go – practically and emotionally. I cannot do everything and I have willingly reduced my self-demands, and I don't think it is a loss.'*

Existential curiosity, monitoring and self-tuning

> *'Work is about finding a wider meaning in life...'*

The analysis also revealed that the nurses related to life and work philosophically. They expressed the belief that they were responsible for finding a life situation that they experienced as meaningful, and in which they also experienced self-respect and self-appreciation.

> *'What's driving me is the need for meaningfulness, self-respect and self-appreciation, and the possibility of working with those people I've been thinking of all these years. It is my duty to find an area of work that I like.'*

Moreover, they described an obligation to contribute, and the belief that the purpose of work is about finding the place where they can contribute to the best of their ability.

> *'My life project is to be a person who stands up for the ones who need me. It is all about living life decently. Talking about it makes me want to weep; it is a nice thing experiencing being in the right place.'*

The analyses also revealed that the participants had the ability to know what was meaningful and which values were the most important to them in life and work.

> *'In my childhood, adolescence and as a young woman I have experienced lack of respect and dignity several times; something happens when you experience being held down, you want to rise up. It is about dignity and worth! That is why I work with demented patients; they can't easily stand up for themselves.'*

The nurses described the will to choose what was perceived as meaningful, and their work-life stories demonstrated their ability actually to make it happen. Their present job situations seemed to be assessed continuously in order to evaluate the position's suitability to work with core values. The participants described how changing jobs implied considering whether the new one helped them to be in an even better position to influence according to important values.

> *'I partly feel I'm in the right place now, but lately I have been focusing on the limitations that prevent me from doing the job even better, so now I'm trying to get to a better position to influence those structural limitations, but it is always the same values and the same clients that are driving me.'*

All in all, the analysis revealed that the nurses were habitually pausing and reflecting to monitor, self-tune and act according to the signals from body, feelings, existential issues and social environment.

Interpretation and discussion

The analysis presented here shows that, when the nurses recognised that their job engagement was undermined by the strain of self-demand, coupled with the rigours of community nursing, they made important changes needed to

regain balance between job demands and resources. The commentary below draws on these findings, and also draws quite heavily on the related findings from two earlier papers in which we analysed interview material from the same sample of eleven nurses. Summarising those earlier results, in our sample of community health nurses who were thriving when we interviewed them, habitual introspection and reflection about job engagement helped them make positive, adaptive adjustments in their working life (Vinje & Mittelmark, 2006a). We also observed that job engagement followed from the nurses' feeling of being called to nursing, which fostered a strong sense of duty and self-demand about their own and others' levels of performance (Vinje & Mittelmark, 2006b). In this way, job engagement can actually contribute to negative processes, leading to poor functioning.

The analysis presented here reveals that the same factors that provided the nurses' lives with meaning, zest and vitality – a strong sense of calling and a good match between vocation and calling – also got them into trouble. Devotion to work, feelings of responsibility and high self-demand led them to psychological vulnerability and deep fatigue. The desire to protect job engagement and to avoid burn-out led the nurses to take stock of their situations and of themselves. This enabled them to make changes in their job situations, or in their own approach to work, that restored job engagement (the focus of this article). Later in this section, we attempt to organise the overall pattern of findings into a coherent model. But first we are concerned with clarifying distinctions between three constructs that we use in the model: introspection, sensibility and reflection.

The nurses showed readiness to act to preserve job engagement. The pattern of vigilance, appraisal and ability to act adaptively calls to mind the construct 'sensibility', used to describe nurses' awareness, receptiveness and understanding of patients' situations (Nortvedt & Grimen, 2004). Sensibility is important because it helps the nurse to 'feel' a patient's subjective experience of disease, health and treatment in ways that can enable better nursing care (Nortvedt & Grimen, 2004). A nurse's comprehension of a patient's pain on an impressionistic level is used as an example of the 'special something' that the construct of sensibility is meant to capture. It is an instance of spontaneous impression that differs from reflection, as reflection implies cognitive distance and does not entail the affectivity and immediacy that characterise sensibility (Nortvedt & Grimen, 2004).

Using the construct sensibility in a new way – to refer to a nurse's self-sensitivity and awareness rather than patient sensitivity and awareness – helps differentiate the roles that introspection and reflection play in self-care. We argue that reflection (systematic cognitive appraisal of events and how one reacts to events) and sensibility (pre-cognitive apprehension of one's inner state) require introspection (self-observation). Introspection is in our analysis, then, the foundation of self-care as the nurses described it. It enables sensibility, which in turn triggers reflection. We argue that in people adept at self-care, relatively constant introspection takes place in the form of sensibility, a pre-reflective, pre-verbal ability which the nurses use to receive and read the signals from their own bodies, emotions, existential depths and the social environment. This triggers reflection when sensibility 'signals' discomfort, imbalance or incongruence. A key element of reflection is self-monitoring, through which one gains appreciation of how events and feelings are related. This enables self-tuning, accomplished through changes in situation and/or self that are intended to restore inner harmony.

In the search for an existing framework in which we can position self-care as we have constructed it above, we are impressed by the utility of the salutogenic perspective of Antonovsky (1979, 1987), and especially his sense of coherence (SOC) construct, a global disposition to see the world as comprehensible, manageable and meaningful. Antonovsky also introduced the concept of boundaries, and argued that only those stimuli that one defines as most important in one's life must be perceived as coherent; among them are one's inner feelings, one's immediate interpersonal relations, one's major activity such as work and one's existential understandings (Antonovsky, 1987).

Sense of coherence is thus a very useful construct in interpretation of the study data. It appears to us that the nurses sought to experience coherence from the innermost experience – sense of calling to nursing, which gives rich meaning to life – to its outer expression in nursing practice. If so, the nurses' stories convey examples of what several researchers have described as the health-promoting benefits of feeling coherence (Antonovsky, 2000; Lindström & Eriksson, 2006; Ventegodt *et al*, 2003). The nurses described the need to balance their idealism with what was realistically achievable in their working situation. They also stated clearly that there is a limit beyond which being a realistic idealist is just resignation. This is consistent with Pines' (1983) idea that burn-out is the result of a process of disillusionment that is typically found among highly motivated individuals.

Dimitrov (2003) argues that the efficiency of one's ability to take care of oneself depends on one's ability to implode – consciously to draw energy inwards. This corresponds to the nurses' stories about inward concentration,

which we have described using the concepts of introspection and sensibility. A consciously guided implosion could, in theory, make it possible to learn from mistakes and transform failures into lessons, and thus grow in wisdom (Dimitrov, 2003). This is demonstrated by the present data. The nurses in our study seemed to use their capacity for introspection, sensibility and reflection to evaluate continuously their job's potential to help them live their core values, and to make necessary changes to ensure coherence between calling and job. When the inner calling of the nurse resonates with and finds its expression in his or her nursing practice, it seems to create an inspirational force which sustains and enhances the experience of job engagement.

Figure 1, opposite, is an attempt to integrate the findings of this and the previous two studies based on interview data obtained from the nurses who talked to us about their philosophies of life, their engagement and dedication to nursing, their experience with burn-out and their return to vitality. Common to all the nurses was the feeling of fulfilment they experienced because they had felt called to nursing; the match between call and vocation was deeply gratifying. This match set the stage for two processes, one in which job engagement gave meaning, zest and vitality to life. All the nurses were habitually introspective; they recognised how nursing gave meaning to life, and were strongly motivated to hold on to that meaning. At the same time, their conscientiousness, dedication and sense of responsibility – self-responsibility and responsibility for others – led them to a work ethic that called for constant improvement and re-doubled effort.

This led, in all but two cases, to overload, deep fatigue and near burn-out (and in one case, to burn-out that resulted in long-term sick leave). The path to ever poorer functioning was signalled by feelings of disquiet and discomfort, which the nurses recognised because they were habitually introspective. This triggered sensibility, self-monitoring, which in turn triggered reflection when the nurses recognised that something had to be done to hold on to the meaningfulness of nursing. In all cases, reflection led to coping of one or both of two types. Some adjustments were to self, typified by learning to moderate demands made on self and on others, to accept that others' ways were acceptable even if not one's own ways. Other adjustments were to situation, including, for example, finding different professional positions in nursing that allowed the nurse to recapture job engagement.

The process as we understand it is systemic and dynamic, as ***Figure 1*** illustrates. Searching for a word or phrase to capture the essence of these processes, the term 'self-tuning' seems particularly appropriate. We have used the term before in a loose way, but here we are more precise, giving it a meaning close to that which it has in systems science.[1] Self-tuning is used to describe regulation in a remarkable range of systems, from the cosmos to the microprocessor. In describing the functioning of computer processors, for example, a self-tuning system detects when operations are out of normal range, and the system dynamically adjusts itself to run at the highest speed it can maintain without generating errors.

It seems reasonable and useful to characterise self-care, as our studies have revealed it, as the product of a self-tuning system. The importance of the systems construct is that it points to the critical importance of all elements in the system. In the system shown in ***Figure 1***, the implication is that all elements are essential for self-care to take place. If a nurse feels no special attachment to nursing as calling, our model suggests that the job engagement and duty processes will not operate at tempos leading either to meaningfulness or to overload. Some elements of the self-tuning model seem likely to go hand in hand, such that the one will usually be present when the other is. For example, having a feeling of calling seems unlikely to be manifest in a person who is not introspective. These are speculations, however, that the present study does not address.

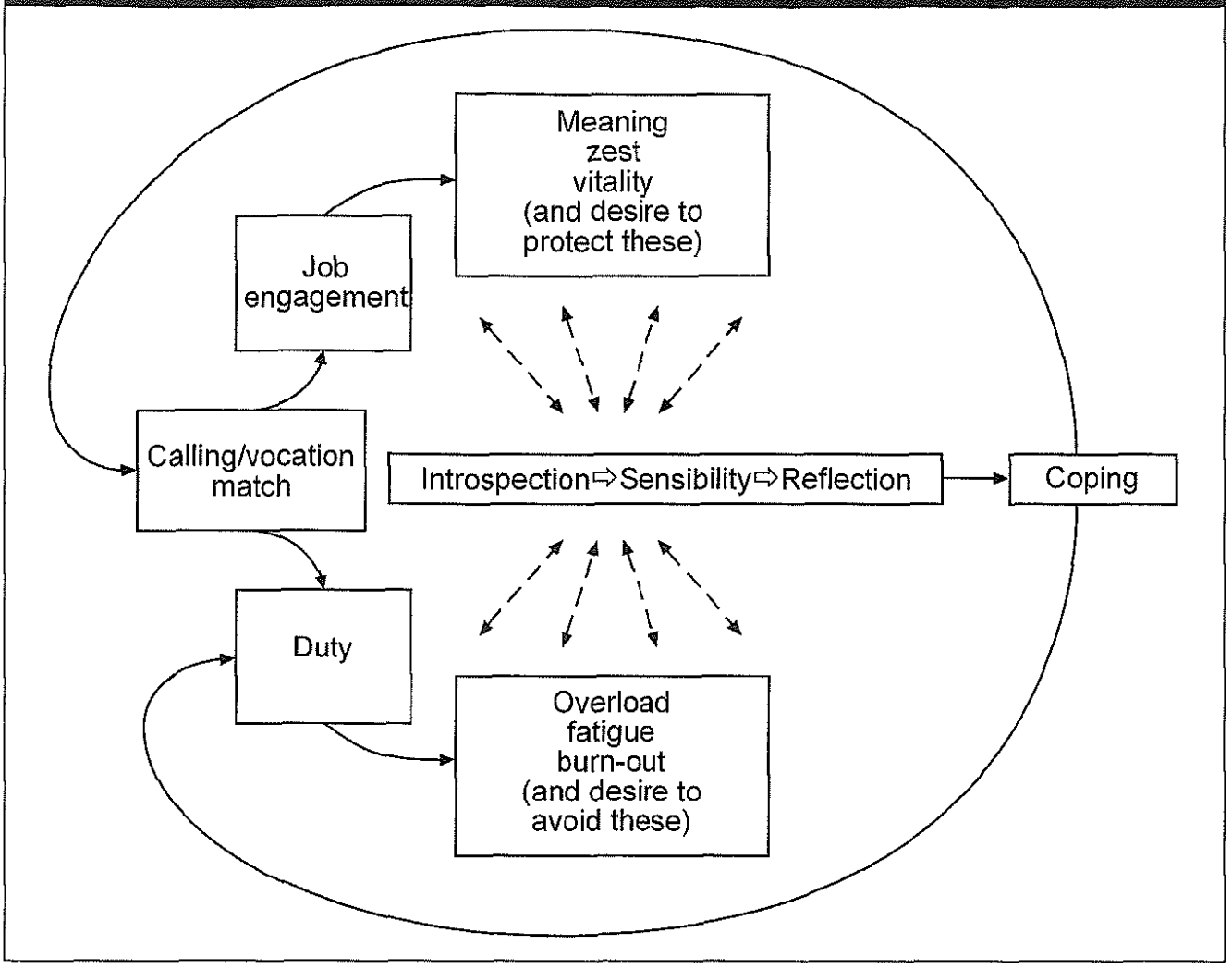
The most intuitive element of the self-tuning system is sensibility, which we have already described as pre-cognitive apprehension of one's inner state. Sensibility seems the Achilles heel of the Self Tuning Model. If it is pre-cognitive, is it innate, and if it is innate, can it be learnt? If not, then self-care as described in this study may not be teachable, and that would reduce our interest in the Self Tuning Model considerably.

Can self-care be learnt?

Nortvedt and Grimen (2004) argue that sensibility is a basic skill that can be learnt, and the first author's experience as a nurse educator supports this contention. Practically speaking, finding time and space for sensibility may be the most important conditions over which one has control. Just as important are an attitude of willingness and a genuine wish to listen to and receive inner signals in an open, accepting, trustful and non-judgemental way. It is probably useful to discuss these phenomena in a group of colleagues or friends, exploring what they mean and involve and how they can be

[1] A self-tuning regulator is 'a type of adaptive control system composed of two loops, an inner loop which consists of the process and an ordinary linear feedback regulator, and an outer loop which is composed of a recursive parameter estimator and a design calculation, and which adjusts the parameters of the regulator'. From McGraw-Hill Dictionary of Scientific and Technical Terms. Retrieved October 22, 2006, from www.answers.com/topic/self-tuning-regulator.

FIGURE 1 *The Self-Tuning Model of Self-Care*



expressed fruitfully. To help detect inner signals, one could use relaxation techniques such as listening to music, walking in nature or engaging in meditation. Expressive techniques like writing, drawing and painting can also be helpful. Focus on one's breath rate can help centre consciousness on the present moment and on signals from body and feelings. This kind of training can be done individually and/or in groups, and in many ways, it resembles mindfulness training.[1]

Limitations

A major limitation of this study is its location in the culture of a small and relatively isolated country. In Norway, traditions of nursing, nurse training and nurse supervision may have developed in ways that are significantly different from those in other places. There is some evidence, for example, that the positioning of nurses in the health care hierarchy may be more complex than in other health systems. Norwegian nurses have the possibility of rising in administrative structures to quite high levels, overseeing large clinical units, and having supervisory responsibility over physicians and all other staff in the unit. Thus the professional position of nursing may have influenced this study in some fundamental way that reduces its relevance to other settings. What is needed is an attempt to replicate the study in a non-Norwegian context.

We also acknowledge that our recruitment strategy worked to select 'superstars' whose job engagement was retained or regained despite bad periods. Clearly missing from our analysis are the stories of nurses who struggle with the same issues as our nurses did, but resolve their situations by leaving nursing.

A very important limitation is that, for the sake of present-

[1] See, for example, www.mindfulnessclasses.com, representative of many resources on the Internet intended to help people learn to pay deep attention to moment-to-moment experience.

ing the study in international journals, we have translated quotations from Norwegian to English. The analysis was conducted in the original language, and we acknowledge the possibility that the tone of language in the quotations may fail to convince readers that our interpretation of the data is justified. However, we know of no way to bridge perfectly the gap between interviews, analyses and interpretations undertaken in one language and reported in another. In such cases, readers have to rely greatly on the skills of the researchers in both languages. In the present case, both authors work in both languages, the first author's mother tongue being Norwegian, and the second author's being English.

Conclusions

We conclude by considering what relevance this study has to the subject of mental health promotion, since the readers of this journal include nurses, and a number of other professionals as well. We believe fundamentally that the Self Tuning Model of Self-care has to be relevant to all stressful professions to which a person may feel called if it is to have any relevance at all. That focuses attention on the construct of 'calling'. If nurses experience calling in a way that few other professions do, a basic assumption of the Self Tuning Model may not be met. That assumption is that the match between calling and vocation is the catalyst for processes leading simultaneously to high job engagement and to highly diligent dutifulness. We assume therefore that vocation in the absence of calling stimulates job engagement and job stress processes other than those we describe, but that is an empirical matter we cannot address with the present data.

However, we argue that all helping professions have the potential to 'call', and that virtually all who engage themselves in the cause of mental health promotion have vocational situations not too dissimilar from nurses'. We infer, therefore, that the Self Tuning Model of Self-care has relevance beyond nursing, encompassing virtually all the helping professions.

Address for correspondence

Hege Forbech Vinje, Assistant Professor, Vestfold University College, Faculty of Health Science, P.O. Box 2243, 3103 Tønsberg, Norway. Phone: +47 33 03 12 64, fax: +47 33 03, 12 90, mobile: +47 48 25 59 60, e-mail: Hege.F.Vinje@hive.no.

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Attachment I

Example of letter of information sent to the recruited nurse

Hege Forbech Vinje

Høgskolen i Vestfold/avdeling for helsefag

Sandefjord,

Kjære

Tusen takk for at du har sagt deg villig til å delta i min intervjuundersøkelse. Undersøkelsen inngår i doktorgradsprosjektet som har tittelen:

"I DE GODE VERDIERS TJENESTE"
- en studie av hvilken betydning fenomenene livskraft, kall og arbeidsglede har for helse i arbeidslivet.

Jeg er for tiden doktorgradsstipendiat ved Høgskolen i Vestfold. Forskerutdanningen får jeg ved psykologisk fakultet ved Universitetet i Bergen. Professor Maurice Mittelmark er hovedveileder for prosjektet. Doktorgradsprosjektet startet 01.08.02 og vil avsluttes 31.07 06.

Studien handler om å øke forståelsen for menneskers opplevelse av arbeidsglede, livskraft og kall i arbeidet i omsorgssektoren. En bedret forståelse av disse fenomenene er grunnleggende for å forstå hvordan og hvorfor mennesker opprettholder arbeidslyst og blir værende i arbeid. Formålet med studien er å forstå forhold som kan skape og opprettholde helse i arbeidslivet.

Du har blitt plukket ut som aktuell deltaker ut fra følgende kriterier;

- Det velges sykepleiere i kommunal helsetjeneste;
- som tilsynelatende utfører arbeidet med engasjement;
- og som tilsynelatende har mye kraft og arbeidsglede

Intervjuene vil bære preg av å være samtaler. Du inviteres til å delta på èn til to intervjusamtaler av ca.1-2 timers varighet. Hensikten er å få fatt i dine tanker, følelser, erfaringer og den mening livskraft, kall og arbeidsglede har for deg som sykepleier. Opplysningene du gir meg vil analyseres i forhold til mening og innhold slik fenomenene fremstår for deg i din arbeidssituasjon. Det vil delta ca femten personer i studien. Som et resultat av den felles dataanalysen er formålet å presentere ny kunnskap om hva som hemmer og fremmer arbeidsglede og livskraft i et arbeidsliv i omsorgssektoren.

Intervjusamtalene vil fortrinnsvis utføres på et egnet rom på din arbeidsplass. Dersom du ønsker det kan vi eventuelt møtes hjemme hos deg. Jeg ber om tillatelse til å ta samtalene opp

på bånd. God analyse og vitenskapelig bearbeiding av dataene blir ellers ikke mulig. Båndene og andre opplysninger du måtte gi meg vil behandles på en slik måte at du sikres full konfidensialitet og anonymisering. Jeg er underlagt taushetsplikt. Du vil selvfølgelig når som helst og uten begrunnelse, kunne avbryte din deltakelse i undersøkelsen. Opplysninger som fremkommer i artikler og i avhandlingen vil ikke kunne tilbakeføres til deg.

Jeg vil ta kontakt med deg på telefon i løpet av fem til ti dager. Dersom du fremdeles ønsker å delta i undersøkelsen kan vi da avtale tid og sted for intervjusamtale. Du er velkommen til å kontakte meg før den tid dersom du skulle ønske det.

Tusen takk nok en gang for din velvillighet!

Vennlig hilsen

Hege F. Vinje/ Stipendiat
Høgskolen i Vestfold/avdeling for helsefag
Postboks 2243,
3103 Tønsberg.

Tlf.:
Mobil:

Attachment II

Acceptance from Norwegian Social Science Data Service

Norsk samfunnsvitenskapelig datatjeneste
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Hans Holmboesgt. 22
N-5007 Bergen
Norway
Tel: +47/ 55 58 21 17
Fax: +47/ 55 58 96 50
E-mail: nsd@nsd.uib.no
www.nsd.uib.no

Hege Forbech Vinje
Avdeling for helsefag
Høgskolen i Vestfold

Postboks 2243
3103 TØNSBERG

Vår dato: 10.02.2003 Vår ref: 200300086 AGM /RH Deres dato: Deres ref:

KVITTERING FRA PERSONVERNOMBUDET

Vi viser til melding om behandling av personopplysninger, mottatt 28.01.2003. Meldingen gjelder prosjektet:

9800 "I de gode verdiers tjeneste..." - en studie av hvilken betydning fenomenene livskraft, kall og arbeidsglede har for helse i arbeidslivet

Norsk samfunnsvitenskapelig datatjeneste AS er utpekt som personvernombud av Høgskolen i Vestfold, jf personopplysningsforskriften § 7-12. Ordningen innebærer at meldeplikten til Datatilsynet er erstattet av meldeplikt til personvernombudet.

Personvernombudets vurdering

Personvernombudet finner at behandlingen av personopplysningene er meldepliktig i henhold til personopplysningsloven § 31 og at behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres slik det er beskrevet i vedlegget. Behandlingen av personopplysninger kan settes i gang.

Ny melding

Det skal gis ny melding dersom behandlingen endres i forhold til de punktene som ligger til grunn for personvernombudets vurdering.

Selv om det ikke skjer endringer i behandlingsopplegget, skal det gis ny melding tre år etter at forrige melding ble gitt dersom prosjektet fortsatt pågår.

Ny melding skal skje skriftlig til personvernombudet.

Offentlig register

Personvernombudet har lagt ut meldingen i et offentlig register, www.nsd.uib.no/personvern/register/

Ny kontakt

Personvernombudet vil ved prosjektets avslutning, 31.07.2006,rette en henvendelse angående status for prosjektet.

Vennlig hilsen

Bjørn Henrichsen

Alette Gilhus Mykkeltvedt

Kontaktperson: Alette Gilhus Mykkeltvedt tlf: 55582174

Vedlegg: Prosjektbeskrivelse

Hege Forbech Vinje
Doktorgradsstipendiat
Høgskolen i Vestfold/avdeling for helsefag

Vestfold, 290107

Universitetet i Bergen
Det psykologiske fakultet
Forskningsutvalget

Ang. fornyet godkjenning fra Norsk samfunnsvitenskapelig datatjeneste (NSD)

NSD's godkjenning var i første omgang gitt fram til 310706.

190106 tok jeg en telefon til kontaktperson Alette Gilhus Mykkeltvedt for å informere om at prosjektet ville løpe utover denne datoen. Mykkeltvedt ga informasjonen til rette vedkommende som ringte meg dagen etter—200106—vedkommende bekreftet at prosjektets forlengelse var registrert og at alt var ok fra deres side.

NSD trengte ingen skriftlig melding.

Hege Forbech Vinje

Doktorgradsstipendiat

Attachment III

Thematic interview guide with examples of questions

TEMATISK INTERVJUGUIDE MED FORSLAG TIL SPØRSMÅL

Arbeidslivshistorien

Kan du fortelle din ”arbeidslivshistorie”?

Hva var det som gjorde at du valgte å utdanne deg til sykepleier?

Hva var det som gjorde at du valgte å arbeide innenfor det området (de områdene) som du gjør?

Kan du eventuelt beskrive hva som gjorde at du valgte et annet arbeidsområde?

Kan du evt beskrive hva som gjorde at du valgte å videreutdanne (omskolere) deg?

Arbeidsglede - det gode arbeidslivet

Hva er det gode arbeidslivet for deg?

Kan du beskrive konkrete situasjoner hvor du har opplevd arbeidsglede?

Hvordan har du det i kroppen, i tankene og hva føler du når arbeidet gir deg glede?

I hvilke situasjoner er det typisk for deg å oppleve arbeidsglede?

Kan du beskrive arbeidsgleden - hva kjennetegner den for deg?

Hvordan vet du at dette er arbeidsglede?

Kall

Hva er det som driver deg? Hva brenner du for?

Hva er det som har trukket deg til din nåværende arbeidssituasjon (og evt tidligere)?

Opplever du å være på rett sted? – hvordan vet du det – kan du beskrive hvordan det kjennes ut?

Hva er det som holder deg i din arbeidssituasjon?

Dersom du har stått i noen såkalte veivalg med hensyn til jobben – kan du beskrive så detaljert som mulig hva som har trukket deg i den ene eller andre retningen?

Hva var det som gjorde at du valgte som du gjorde til slutt?

Livskraft

Kan du beskrive konkrete situasjoner hvor du har opplevd å ha stor livskraft – mye energi?

I hvilke situasjoner er det typisk? – evt eksempler på det motsatte?

Hvordan vil du beskrive livskraften - hva kjennetegner den for deg?

Hvordan har du det i kroppen, i tankene og hva føler du når arbeidet kjennetegnes av å gi deg stor kraft?

Hva utløser slik kraft for deg?

Verdier og mening

Hvilken betydning har det for deg at arbeidet oppleves meningsfullt?

Hvilke verdier er det viktig at arbeidet gir deg mulighet for å virkeliggjøre?

Hva er det overordnede målet med det arbeidet du utfører slik du ser det?

Hvordan vil du beskrive din livsfilosofi? - den overordende forståelsen du har av livet og det å være menneske?

Hva er meningen med livet for deg?

Omsorg for deg selv

Kan du beskrive hvordan du drar omsorg for deg selv fysisk, psykisk, sosialt og åndelig?

Hva tenker du om sammenhengen mellom det å dra omsorg for seg selv og det å være omsorgsgiver?

Helhetlig kommunikasjon

Beskrive konkrete situasjoner?

Har du noen eksempler?

Kan du utdype?

Hva tenker du om dette?

Hvilke følelser gir det deg?

Jeg ser at du berøres – vil du beskrive hva som skjer?

Forslag til forståelse?

Er det noe du vil tilføye?

Er det noe du vil utdype

Er det noe jeg har glemt?

Er det noe du lurer på?

Er det noe du vil spørre meg om?

Attachment IV

Example of letter attached to the transcription when returned to the nurse for comments

Hege Forbech Vinje
Høgskolen i Vestfold/avdeling for helsefag

Sandefjord,

Kjære

Takk for sist!

Jeg har nå skrevet ut samtalen vår, og sender deg som vi avtalte et eksemplar av transkripsjonen til gjennomlesning. Dersom det er noe du ønsker å utdype er du velkommen til det ved å vedlegge dine skriftlige kommentarer når du sender transkripsjonen tilbake til meg. Jeg har vedlagt en frankert og adressert konvolutt du kan benytte. Dersom alt er ok, skriver du bare det. Har du lyst til å skrive litt om hvordan det var å delta i samtalen er du velkommen til det.

Det skriftlige og muntlige språket er forskjellig. Det kan derfor virke rart å se sitt muntlige språk på trykk. Når jeg lytter til båndet, høres alt normalt ut. Som du vil se så har jeg av anonymitetshensyn byttet ditt navn med et pseudonym. Din identitet oppbevares ikke sammen med transkripsjonen.

Tusen takk nok en gang for at du sa deg villig til å være med i min undersøkelse.
Jeg ønsker deg alt godt videre i liv og arbeid!

Vennlig hilsen

Hege F. Vinje

Vedlegg.

Attachment V

An example of analysis: zest for work

An example of analysis: zest for work

The entire study was conducted in Norwegian, including the interviews, transcriptions and analysis. Below, however, I will present a sequence translated into English in order to provide an example of the analytical process. In this sequence the nurse and I are talking about zest for work. I will move directly to step 2 as steps 1a and 1b are described in detail above.

Step 2: Dividing the text into fragments of meaning (meaning units)

The text was divided into meaning units in regard to zest for work. Although the dividing into meaning units would be guided by the phenomenon being studied, I aimed in this step to be true to the nurse's descriptions. The dividing into meaning units was supposed to be spontaneous and non-theoretical. I marked the text by placing a number where the meaning changed. The general impression I had gained of the interview helped me to understand the meaning of these units. At this stage of the analysis, the text was not altered beyond the consecutive numbering of the meaning units.

I: *What is it that makes you feel zest for work? Do you have any thoughts on that?*
Nurse*: 1) When I experience people mastering things, there is something about that. 2) As a leader I find it very alright when my co-workers are thriving, 3) and that they find courage to solve the tasks they are supposed to solve, that they trust themselves and see that this is a way to handle it, 'I am mastering this, I will handle this'. 4) And I am truly happy when I hear them expressing themselves in such a way that I understand that they have basic perspectives of the job that I agree to. Then it is like…oh yes…it is such a good, a wonderful feeling of being so lucky to being allowed to work with such persons who think like this, and want to take on these tasks and feel enriched by working in these situations and feel that they have something to give and find it exciting and fun to work with families having a lot of challenges, then I am very happy!*
I: *Is this an example of a situation where you experience zest for work?*
Nurse*: 5) Yes, and when my colleagues come into my office and say: 'can we talk a bit; I would like to share this with you. Not because I want an answer from you, but…' So that I experience that someone has trust in me as a conversation partner, and that people say when leaving: 'it was good talking to you! Now everything is clearer. Everything will be fine!' 6) To feel that we are underway, that things happen, that we can struggle a bit, as I said earlier, that I sometimes possibly present too many challenges, but at the same time experience that people appreciate them and take them on. So that we can get back to it and say: 'I was very provoked when you said what you did, but now I can see that…' or 'this has been frustrating, but now I can see that this has been very important to us'. Then my day is saved! (Laughs). And from time to time I am so lucky that I am able to work with some clients and that*

is perhaps more about 7) me getting confirmed that I still am fit as a nurse and practicing as a public health nurse, by and large I find these experiences very positive, I think I am lucky to have them, it is such experiences that touch me 8) that people actually have trust in me (starting to cry).

Step 3: Transforming the meaning units

The content of the meaning units was transformed into theoretical expressions, while still preserving the core of the nurse's description. This was carried out through reflecting theoretically about the perspectives chosen for the study, and by approaching the task of transforming the meaning units into theoretical expressions as intuitively and creatively as possible. I was searching for the meaning and essence of the phenomena 'zest for work' as the nurse described it.

1) The nurse is a leader, and she says that she experiences zest for work when her fellow workers succeed.

2) She also describes experiencing zest for work when her fellow workers say that they are thriving

3) In this meaning unit, the nurse is returning to the point of her co-workers succeeding. She is specifying that zest for works is related to when her co-workers feel that they master their work and have faith in that they are able to solve tasks. Seeing this in her co-workers awakens her zest for work.

4) Working together with 'soul-mates' also gives her zest for work; when her fellow workers express in words and actions the same values that she herself also finds important. (She has described these values earlier in the interview. Thus, the general impression of the interview as a whole helped me understand the content of this meaning unit.)

5) She has zest for work when her co-workers show that they trust her and that they see her as a good conversation partner, and they therefore invite her to be part of a conversation.

6) She also has zest for work when she experiences that both she and her co-workers are developing their competence at work and that she has contributed to their growth

7) She experiences zest for work when mastering her work with clients.

8) In this meaning unit she is returning to the fact that people trust her. She refers here to both her co-workers and her clients.

Step 4: Meaning condensation and the creations of codes and categories

In step 4, I made interpretations at a higher level of abstraction, while at the same time trying to give a faithful description of zest for work as it appeared in the nurse's story. The nurse reports that she experiences zest for work when the people she relates to at her work show her trust. For her, it is an expression of trust when her co-workers invite her to talk about difficulties at work, and when clients are open with her in her work as a public health nurse. She is touched emotionally when she talks about trust experienced like this. Further, she experiences zest for work when her co-workers say that they are thriving at work and being successful in and mastering, their jobs. I understand that she sees this as an expression of her doing her job as a leader well. She also says that she experiences zest for work when she can contribute to the development and growth of others, and that of herself. (Another place in the interview she tells that it gives her zest for work when she sees that her clients are managing their lives, and when they are able to make important changes, for example, in regard to the upbringing of their children) Once again, my detailed knowledge of the whole interview helped me to find meaning in this particular section of the interview. In these above instances, zest for work appears to be tied to her experience of being of importance to other human beings. By showing her their trust, she can contribute to their experience of improvement in their lives, or of wanting to grow and develop further. It seems as though this has to do with the experience of being of use to other people. Finally, the nurse experiences zest for work when those she works with express the same kinds of values that she herself stands for, and believes in.

From the above, I came to understand that zest for work, as described by the nurse, is essentially about;

1. others trusting her to contribute positively to their lives
2. the experience of mastery, doing her job well and co-development
3. the realization of central values through working together with others

From these codes, I also created categories as presented in figure 1, below.

Step 5: Searching for themes, understood as the expression of latent content

Searching for themes and the latent content of the interview texts is a process that emerges after having conducted the analysis over a period of time. I did not arrive at an understanding of the latent content of the material on the basis of one interview text. Rather, this was the result of analyzing all the interview texts case by case and cross-case. I have included a sub-theme and a theme in figure 1 as an illustration. The sub-theme and theme did not, however, emerge from this sequence alone.

Meaning unit	Condensed meaning unit	Code	Category	Sub-theme	Theme
that people actually have trust in me	she experiences zest for work when the persons she relates to at her work show her trust.	others trusting her to contribute positively to their lives	The experience of contributing to other people's lives	Experiencing meaningfulness	Introspection
To feel that we are underway, that things happen, that we can struggle a bit, as I said earlier, that I sometimes possibly present to many challenges, but at the same time experience that people appreciate them and take them on	she experiences zest for work when she and her co-workers are developing and that she has contributed to the growth of her co-workers and of herself	the experience of mastery, doing her job well and co-development	Mastery, learning, personal and professional growth		
And I am truly happy when I hear them expressing themselves in such a way that I understand that they have basic perspectives of the job that I agree to.	She experiences zest for work when those she works with express the same kind of values that she herself stands for and believes in.	to realize central values through working together with others	Creating values		

Figure 2. Examples of meaning units, condensed meaning units, codes, categories, sub-theme and theme.

Doctoral Theses at The Faculty of Psychology, University of Bergen

1980	Allen, H.M., Dr. philos.	Parent-offspring interactions in willow grouse (Lagopus L. Lagopus).
1981	Myhrer, T., Dr. philos.	Behavioral Studies after selective disruption of hippocampal inputs in albino rats.
1982	Svebak, S., Dr. philos.	The significance of motivation for task-induced tonic physiological changes.
1983	Myhre, G., Dr. philos.	The Biopsychology of behavior in captive Willow ptarmigan.
	Eide, R., Dr. philos.	PSYCHOSOCIAL FACTORS AND INDICES OF HEALTH RISKS. The relationship of psychosocial conditions to subjective complaints, arterial blood pressure, serum cholesterol, serum triglycerides and urinary catecholamines in middle aged populations in Western Norway.
	Værnes, R.J., Dr. philos.	Neuropsychological effects of diving.
1984	Kolstad, A., Dr. philos.	Til diskusjonen om sammenhengen mellom sosiale forhold og psykiske strukturer. En epidemiologisk undersøkelse blant barn og unge.
	Løberg, T., Dr. philos.	Neuropsychological assessment in alcohol dependence.
1985	Hellesnes, T., Dr. philos.	Læring og problemløsning. En studie av den perseptuelle analysens betydning for verbal læring.
	Håland, W., Dr. philos.	Psykoterapi: relasjon, utviklingsprosess og effekt.
1986	Hagtvet, K.A., Dr. philos.	The construct of test anxiety: Conceptual and methodological issues.
	Jellestad, F.K., Dr. philos.	Effects of neuron specific amygdala lesions on fear-motivated behavior in rats.
1987	Aarø, L.E., Dr. philos.	Health behaviour and sosioeconomic Status. A survey among the adult population in Norway.
	Underlid, K., Dr. philos.	Arbeidsløyse i psykososialt perspektiv.
	Laberg, J.C., Dr. philos.	Expectancy and classical conditioning in alcoholics' craving.
	Vollmer, F.C., Dr. philos.	Essays on explanation in psychology.
	Ellertsen, B., Dr. philos.	Migraine and tension headache: Psychophysiology, personality and therapy.
1988	Kaufmann, A., Dr. philos.	Antisosial atferd hos ungdom. En studie av psykologiske determinanter.

	Mykletun, R.J., Dr. philos.	Teacher stress: personality, work-load and health.
	Havik, O.E., Dr. philos.	After the myocardial infarction: A medical and psychological study with special emphasis on perceived illness.
1989	Bråten, S., Dr. philos.	Menneskedyaden. En teoretisk tese om sinnets dialogiske natur med informasjons- og utviklingspsykologiske implikasjoner sammenholdt med utvalgte spedbarnsstudier.
	Wold, B., Dr. psychol.	Lifestyles and physical activity. A theoretical and empirical analysis of socialization among children and adolescents.
1990	Flaten, M.A., Dr. psychol.	The role of habituation and learning in reflex modification.
1991	Alsaker, F.D., Dr. philos.	Global negative self-evaluations in early adolescence.
	Kraft, P., Dr. philos.	AIDS prevention in Norway. Empirical studies on diffusion of knowledge, public opinion, and sexual behaviour.
	Endresen, I.M., Dr. philos.	Psychoimmuniological stress markers in working life.
	Faleide, A.O., Dr. philos.	Asthma and allergy in childhood. Psychosocial and psychotherapeutic problems.
1992	Dalen, K., Dr. philos.	Hemispheric asymmetry and the Dual-Task Paradigm: An experimental approach.
	Bø, I.B., Dr. philos.	Ungdoms sosiale økologi. En undersøkelse av 14-16 åringers sosiale nettverk.
	Nivison, M.E., Dr. philos.	The relationship between noise as an experimental and environmental stressor, physiological changes and psychological factors.
	Torgersen, A.M., Dr. philos.	Genetic and environmental influence on temperamental behaviour. A longitudinal study of twins from infancy to adolescence.
1993	Larsen, S., Dr. philos.	Cultural background and problem drinking.
	Nordhus, I.H., Dr. philos.	Family caregiving. A community psychological study with special emphasis on clinical interventions.
	Thuen, F., Dr. psychol.	Accident-related behaviour among children and young adolescents: Prediction and prevention.
	Solheim, R., Dr. philos.	Spesifikke lærevansker. Diskrepanskriteriet anvendt i seleksjonsmetodikk.
	Johnsen, B.H., Dr. psychol.	Brain assymetry and facial emotional expressions: Conditioning experiments.
1994	Tønnessen, F.E., Dr. philos.	The etiology of Dyslexia.
	Kvale, G., Dr. psychol.	Psychological factors in anticipatory nausea and vomiting in cancer chemotherapy.
	Asbjørnsen, A.E., Dr. psychol.	Structural and dynamic factors in dichotic listening: An interactional model.

	Bru, E., Dr. philos.	The role of psychological factors in neck, shoulder and low back pain among female hospitale staff.
	Braathen, E.T., Dr. psychol.	Prediction of exellence and discontinuation in different types of sport: The significance of motivation and EMG.
	Johannessen, B.F., Dr. philos.	Det flytende kjønnet. Om lederskap, politikk og identitet.
1995	Sam, D.L., Dr. psychol.	Acculturation of young immigrants in Norway: A psychological and socio-cultural adaptation.
	Bjaalid, I.-K., Dr. philos	Component processes in word recognition.
	Martinsen, Ø., Dr. philos.	Cognitive style and insight.
	Nordby, H., Dr. philos.	Processing of auditory deviant events: Mismatch negativity of event-related brain potentials.
	Raaheim, A., Dr. philos.	Health perception and health behaviour, theoretical considerations, empirical studies, and practical implications.
	Seltzer, W.J., Dr.philos.	Studies of Psychocultural Approach to Families in Therapy.
	Brun, W., Dr.philos.	Subjective conceptions of uncertainty and risk.
	Aas, H.N., Dr. psychol.	Alcohol expectancies and socialization: Adolescents learning to drink.
	Bjørkly, S., Dr. psychol.	Diagnosis and prediction of intra-institutional aggressive behaviour in psychotic patients
1996	Anderssen, N., Dr. psychol.	Physical activity of young people in a health perspective: Stability, change and social influences.
	Sandal, Gro Mjeldheim, Dr. psychol.	Coping in extreme environments: The role of personality.
	Strumse, Einar, Dr. philos.	The psychology of aesthetics: explaining visual preferences for agrarian landscapes in Western Norway.
	Hestad, Knut, Dr. philos.	Neuropsychological deficits in HIV-1 infection.
	Lugoe, L.Wycliffe, Dr. philos.	Prediction of Tanzanian students' HIV risk and preventive behaviours
	Sandvik, B. Gunnhild, Dr. philos.	Fra distriktsjordmor til institusjonsjordmor. Fremveksten av en profesjon og en profesjonsutdanning
	Lie, Gro Therese, Dr. psychol.	The disease that dares not speak its name: Studies on factors of importance for coping with HIV/AIDS in Northern Tanzania
	Øygard, Lisbet, Dr. philos.	Health behaviors among young adults. A psychological and sociological approach
	Stormark, Kjell Morten, Dr. psychol.	Emotional modulation of selective attention: Experimental and clinical evidence.
	Einarsen, Ståle, Dr. psychol.	Bullying and harassment at work: epidemiological and psychosocial aspects.

1997	Knivsberg, Ann-Mari, Dr. philos.	Behavioural abnormalities and childhood psychopathology: Urinary peptide patterns as a potential tool in diagnosis and remediation.
	Eide, Arne H., Dr. philos.	Adolescent drug use in Zimbabwe. Cultural orientation in a global-local perspective and use of psychoactive substances among secondary school students.
	Sørensen, Marit, Dr. philos.	The psychology of initiating and maintaining exercise and diet behaviour.
	Skjæveland, Oddvar, Dr. psychol.	Relationships between spatial-physical neighborhood attributes and social relations among neighbors.
	Zewdie, Teka, Dr. philos.	Mother-child relational patterns in Ethiopia. Issues of developmental theories and intervention programs.
	Wilhelmsen, Britt Unni, Dr. philos.	Development and evaluation of two educational programmes designed to prevent alcohol use among adolescents.
	Manger, Terje, Dr. philos.	Gender differences in mathematical achievement among Norwegian elementary school students.
1998		
V	Lindstrøm, Torill Christine, Dr. philos.	«Good Grief»: Adapting to Bereavement.
	Skogstad, Anders, Dr. philos.	Effects of leadership behaviour on job satisfaction, health and efficiency.
	Haldorsen, Ellen M. Håland, Dr. psychol.	Return to work in low back pain patients.
	Besemer, Susan P., Dr. philos.	Creative Product Analysis: The Search for a Valid Model for Understanding Creativity in Products.
H	Winje, Dagfinn, Dr. psychol.	Psychological adjustment after severe trauma. A longitudinal study of adults' and children's posttraumatic reactions and coping after the bus accident in Måbødalen, Norway 1988.
	Vosburg, Suzanne K., Dr. philos.	The effects of mood on creative problem solving.
	Eriksen, Hege R., Dr. philos.	Stress and coping: Does it really matter for subjective health complaints?
	Jakobsen, Reidar, Dr. psychol.	Empiriske studier av kunnskap og holdninger om hiv/aids og den normative seksuelle utvikling i ungdomsårene.
1999		
V	Mikkelsen, Aslaug, Dr. philos.	Effects of learning opportunities and learning climate on occupational health.
	Samdal, Oddrun, Dr. philos.	The school environment as a risk or resource for students' health-related behaviours and subjective well-being.
	Friestad, Christine, Dr. philos.	Social psychological approaches to smoking.
	Ekeland, Tor-Johan, Dr. philos.	Meining som medisin. Ein analyse av placebofenomenet og implikasjoner for terapi og terapeutiske teoriar.
H	Saban, Sara, Dr. psychol.	Brain Asymmetry and Attention: Classical Conditioning Experiments.

	Carlsten, Carl Thomas, Dr. philos.	God lesing – God læring. En aksjonsrettet studie av undervisning i fagtekstlesing.
	Dundas, Ingrid, Dr. psychol.	Functional and dysfunctional closeness. Family interaction and children's adjustment.
	Engen, Liv, Dr. philos.	Kartlegging av leseferdighet på småskoletrinnet og vurdering av faktorer som kan være av betydning for optimal leseutvikling.
2000		
V	Hovland, Ole Johan, Dr. philos.	Transforming a self-preserving "alarm" reaction into a self-defeating emotional response: Toward an integrative approach to anxiety as a human phenomenon.
	Lillejord, Sølvi, Dr. philos.	Handlingsrasjonalitet og spesialundervisning. En analyse av aktørperspektiver.
	Sandell, Ove, Dr. philos.	Den varme kunnskapen.
	Oftedal, Marit Petersen, Dr. philos.	Diagnostisering av ordavkodingsvansker: En prosessanalytisk tilnærmingsmåte.
H	Sandbak, Tone, Dr. psychol.	Alcohol consumption and preference in the rat: The significance of individual differences and relationships to stress pathology
	Eid, Jarle, Dr. psychol.	Early predictors of PTSD symptom reporting; The significance of contextual and individual factors.
2001		
V	Skinstad, Anne Helene, Dr. philos.	Substance dependence and borderline personality disorders.
	Binder, Per-Einar, Dr. psychol.	Individet og den meningsbærende andre. En teoretisk undersøkelse av de mellommenneskelige forutsetningene for psykisk liv og utvikling med utgangspunkt i Donald Winnicotts teori.
	Roald, Ingvild K., Dr. philos.	Building of concepts. A study of Physics concepts of Norwegian deaf students.
H	Fekadu, Zelalem W., Dr. philos.	Pridicting contraceptive use and intention among a sample of adolescent girls. An application of the theory of planned behaviour in Ethiopian context.
	Melesse, Fantu, Dr. philos.	The more intelligent and sensitive child (MISC) mediational intervention in an Ethiopian context: An evaluation study.
	Råheim, Målfrid, Dr. philos.	Kvinners kroppserfaring og livssammenheng. En fenomenologisk – hermeneutisk studie av friske kvinner og kvinner med kroniske muskelsmerter.
	Engelsen, Birthe Kari, Dr. psychol.	Measurement of the eating problem construct.
	Lau, Bjørn, Dr. philos.	Weight and eating concerns in adolescence.
2002		
V	Ihlebæk, Camilla, Dr. philos.	Epidemiological studies of subjective health complaints.
	Rosén, Gunnar O. R., Dr. philos.	The phantom limb experience. Models for understanding and treatment of pain with hypnosis.

	Høines, Marit Johnsen, Dr. philos.	Fleksible språkrom. Matematikklæring som tekstutvikling.
	Anthun, Roald Andor, Dr. philos.	School psychology service quality. Consumer appraisal, quality dimensions, and collaborative improvement potential
	Pallesen, Ståle, Dr. psychol.	Insomnia in the elderly. Epidemiology, psychological characteristics and treatment.
	Midthassel, Unni Vere, Dr. philos.	Teacher involvement in school development activity. A study of teachers in Norwegian compulsory schools
	Kallestad, Jan Helge, Dr. philos.	Teachers, schools and implementation of the Olweus Bullying Prevention Program.
H	Ofte, Sonja Helgesen, Dr. psychol.	Right-left discrimination in adults and children.
	Netland, Marit, Dr. psychol.	Exposure to political violence. The need to estimate our estimations.
	Diseth, Åge, Dr. psychol.	Approaches to learning: Validity and prediction of academic performance.
	Bjuland, Raymond, Dr. philos.	Problem solving in geometry. Reasoning processes of student teachers working in small groups: A dialogical approach.
2003		
V	Arefjord, Kjersti, Dr. psychol.	After the myocardial infarction – the wives' view. Short- and long-term adjustment in wives of myocardial infarction patients.
	Ingjaldsson, Jón Þorvaldur, Dr. psychol.	Unconscious Processes and Vagal Activity in Alcohol Dependency.
	Holden, Børge, Dr. philos.	Følger av atferdsanalytiske forklaringer for atferdsanalysens tilnærming til utforming av behandling.
	Holsen, Ingrid, Dr. philos.	Depressed mood from adolescence to 'emerging adulthood'. Course and longitudinal influences of body image and parent-adolescent relationship.
	Hammar, Åsa Karin, Dr. psychol.	Major depression and cognitive dysfunction- An experimental study of the cognitive effort hypothesis.
	Sprugevica, Ieva, Dr. philos.	The impact of enabling skills on early reading acquisition.
	Gabrielsen, Egil, Dr. philos.	LESE FOR LIVET. Lesekompetansen i den norske voksenbefolkningen sett i lys av visjonen om en enhetsskole.
H	Hansen, Anita Lill, Dr. psychol.	The influence of heart rate variability in the regulation of attentional and memory processes.
	Dyregrov, Kari, Dr. philos.	The loss of child by suicide, SIDS, and accidents: Consequences, needs and provisions of help.
2004		
V	Torsheim, Torbjørn, Dr. psychol.	Student role strain and subjective health complaints: Individual, contextual, and longitudinal perspectives.
	Haugland, Bente Storm Mowatt Dr. psychol.	Parental alcohol abuse. Family functioning and child adjustment.

	Milde, Anne Marita, Dr. psychol.	Ulcerative colitis and the role of stress. Animal studies of psychobiological factors in relationship to experimentally induced colitis.
	Stornes, Tor, Dr. philos.	Socio-moral behaviour in sport. An investigation of perceptions of sportspersonship in handball related to important factors of socio-moral influence.
	Mæhle, Magne, Dr. philos.	Re-inventing the child in family therapy: An investigation of the relevance and applicability of theory and research in child development for family therapy involving children.
	Kobbeltvedt, Therese, Dr. psychol.	Risk and feelings: A field approach.
H	Thomsen, Tormod, Dr. psychol.	Localization of attention in the brain.
	Løberg, Else-Marie, Dr. psychol.	Functional laterality and attention modulation in schizophrenia: Effects of clinical variables.
	Kyrkjebø, Jane Mikkelsen, Dr. philos.	Learning to improve: Integrating continuous quality improvement learning into nursing education.
	Laumann, Karin, Dr. psychol.	Restorative and stress-reducing effects of natural environments: Experiencal, behavioural and cardiovascular indices.
	Holgersen, Helge, PhD	Mellom oss - Essay i relasjonell psykoanalyse.
2005		
V	Hetland, Hilde, Dr. psychol.	Leading to the extraordinary? Antecedents and outcomes of transformational leadership.
	Iversen, Anette Christine, Dr. philos.	Social differences in health behaviour: the motivational role of perceived control and coping.
H	Mathisen, Gro Ellen, PhD	Climates for creativity and innovation: Definitions, measurement, predictors and consequences.
	Sævi, Tone, Dr. philos.	Seeing disability pedagogically – The lived experience of disability in the pedagogical encounter.
	Wiium, Nora, PhD	Intrapersonal factors, family and school norms: combined and interactive influence on adolescent smoking behaviour.
	Kanagaratnam, Pushpa, PhD	Subjective and objective correlates of Posttraumatic Stress in immigrants/refugees exposed to political violence.
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