

2017

The Meaning of Feeling Fearful for New Community/Public Health Nurses

Demetrius Ann Jones
Walden University

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Walden University

College of Health Sciences

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Demetrius Jones

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Walden University
June 2017

Abstract

The Meaning of Feeling Fearful for New Community/Public Health Nurses

by

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MSN, Wilmington University, 2008

BSN, University of Maryland School of Nursing, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

June 2017

Abstract

This study examined the meaning of feeling fearful for nurses entering community/public health (C/PH) nursing. Nurses are entering the C/PH workforce with less experience and education than ever before, and may feel afraid or fearful in their jobs. Additionally, the autonomous nature of C/PH nursing poses significant challenges for this population such as fear of isolation and/ or abandonment. Therefore, the purpose of this qualitative descriptive study was to explicate the meaning of feeling fearful for new C/PH health nurses. Ten nurses with up to 2 years of C/PH experience volunteered for this study. The research questions were guided by the humanbecoming theory and its objectives. The 3 objectives were to describe the significance of feeling fearful; rhythmical patterns of relating connected to feeling fearful; and the concerns, plans, hopes, and dreams related to feeling fearful. Participants provided narratives via face-to-face and telephone interviews. Data were analyzed using manual coding, analysis-synthesis, and were documented in humanbecoming language. The findings revealed a feeling of fear as a disquieting unease arising with the unforeseen, with unpredictable affiliations surfacing amid diverse encounters, and as pondering possibilities arise with potent assuredness. These findings may influence positive social change by providing an opportunity for hospital administrators, nursing faculty, and public health agencies to dialogue about fearful experiences that new C/PH nurses encounter. Moreover, this study could stimulate ideas that foster nonthreatening learning environments in academic nursing programs, C/PH orientations, and nursing residencies.

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Dedication

I dedicate this project to my loving husband, Wilbur M. Jones Jr. and my late grandmother Emma Lee Mason. Wilbur, you continue to support me and provide an example of strength and faith for all to follow. My grandmother loved education and I am grateful to her for imparting to me a passion for God, nursing, and education. God has blessed me as you have been an integral part of my life. Thank you for the love you have shown me throughout this process and my life. You have shown me that courage is not the absence of fear, it is pressing forward in the midst of feeling fearful.

Fear I talk to you

You bind like a noose

So tight around my chest

I am so stressed

Where is my song?

Life's melody is gone

Lord, pull me through

Fear, I talk to you

Demetrius Jones 2016

Acknowledgments

The doctoral journey is not for the faint of heart. Emotions such as loneliness, fear, and frustration are often used to describe the doctoral process. On-the other-hand, joy, gratitude, humility, and fulfillment are also emotions associated with this endeavor. I have experienced each of these emotions and I am better for it. I want to take this opportunity to thank Dr. M. Nicholas Coppola (Dr. Nick) who was my first professor at Walden University. Dr. Nick reminded me to have fun, and I never forgot his advice. Thank you Dr. Steve Materelli, who cultivated a deep respect for APA formatting, your support will not be forgotten. Dr. Jeanette May, I truly appreciate your guidance and patience during the initial phase of this journey. Thank you Dr. Magdeline Aagard for picking up the baton as Chair, carrying me to the finish line. Thank you Dr. Roland Thorpe and Dr. Daniel Okenu for your commitment toward my study. Thank you Dr. Tammy Root and Dr. Steve Bowmen for being there to help whenever I needed your assistance. To my husband, Wilbur M. Jones Jr., and family, you are amazing! Many thanks to my Virginia family and new family, church family at Epic Community Church and Oak Grove Baptist Church for praying for me. Thank you to Walden's editing staff, my Community Partner, peer advisors, scholar-practioners, reviewers, and babysitters for your assistance toward my doctoral degree. Thank you Dr. Parse, Dr. Bunkers, and Parse scholars for your positive energy, expertise, and prayers throughout this journey! Most of all, thank you Lord Jesus for all you have done for me! To God be all the glory! Isaiah 41:13 ESV states: For I, the Lord your God, hold your right hand; it is I who say to you, "Fear not, I am the one who helps you"

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Chapter 1: Introduction to the Study

Introduction

The transition from nursing student to professional nurse is marked with fear and humility (Sneltvedt, Odland, & Sorlie, 2010). The phenomenon of fear is briefly noted in a study about new graduates entering the profession of home health (HH) nursing (Sneltvedt et al., 2010). Nursing graduates face numerous challenges when entering the nursing workforce, causing them to leave the profession (Kramer, 1974; Sneltvedt et al., 2010). Additionally, increased nursing shortages and poor work environments have created an unstable workforce in communities throughout the United States (Schofield, Ganann, Brooks, McGugan, Bona, Betker, Dilworth, Parton, Reid-Haughian, Slepko & Watson, 2011). About 62% of registered nurses work in a hospital, and only 7.8% work in community/public health (C/PH) settings. The HH setting includes 6.4% of the nursing workforce (American Nurses Association [ANA, 2010]). At present, few qualitative studies have explored the meaning of feeling fearful for new nurses entering C/PH nursing.

This study explored feeling fearful for new nurses entering C/PH. This inquiry has the potential to: (a) explicate the meaning of feeling fearful, (b) contribute to the understanding of the experience of feeling fearful for new nurses entering C/PH settings, and (c) contribute to an extant body of knowledge using the humanbecoming paradigm, thus filling a gap in the literature.

The major sections in this chapter are the background, problem statement, purpose, research questions, conceptual framework, nature of the study, and definitions.

I then address assumptions, limitations, scope, delimitations, significance, and possible social change. Lastly, I summarized the major aspects of this chapter and provide a transition into Chapter 2.

Background

Fear is a universal living experience that molds humankind and is significant for graduate nurses entering the field of community nursing (Baumann, 2009; Kramer, 1974). Earlier research documents the *reality shock* experienced by nursing students and graduate nurses as they entered the nursing workforce in various settings (Kramer, 1974). Kramer coined the term reality shock as the conflict that existed when school values conflicted with world values as a nursing student began working in the hospital (Kramer, 1974). Emotions such as fear, anxiety, shock, and disorientation plague nurses as they attempted to navigate this new world (Kramer, 1974). Another study by Sneltvedt, Odland, and Sorlie discovered that new nurses who enter HH face the unique challenge of loneliness and fear during the first year and beyond (2010). New nurses felt unprepared for what faced them, which exemplified reality shock in the C/PH setting (Sneltvedt et al., 2010).

Experienced nurses perceived graduate nurses as needy and reported that more were leaving the position in less than a year (Ballem & Macintosh, 2014). Nurses within 1 year of practice or graduate nurses found the transition into the working world stressful because they lacked experience and confidence (Qiao & Hu, 2011). The continual decrease in C/PH nurses further contributes to an unstable workforce. Few studies

addressed feeling fearful in C/PH. This study addressed this gap in the literature by exploring the meaning of feeling fearful as nurses entered the workforce in C/PH settings.

Problem Statement

C/PH and HH nurses made up less than 15% of the nursing workforce nationally according to 2010 data (ANA, 2010). The projected need for registered nurses in Maryland will be 72,000 by 2025. This study focused on C/PH data for Maryland and surrounding areas. If the number of new nurse graduates pass the National Council Licensure Exam for Registered Nurses (NCLEX-RN) and work in Maryland, about 59,900 new nurses will enter the workforce, still leaving a deficit of 12,100 positions not filled by 2025 (ANA, 2010). A report from the United States Department of Health and Human Services (HRSA) noted that 150, 000 new nurse graduates will enter the workforce between 2012 and 2013 (HRSA, 2014). The projection of RN's needed nationally was 21% by 2025 (HRSA, 2014). This will further debilitate the C/PH workforce since most agencies require a nurse to have at least 1 year of hospital experience to be considered for a HH nurse position (Breakwell, 2004). This requirement increases the deficit of nurses needed in the C/PH field (ANA, 2010).

According to Kramer and Breakwell, creative training, recruitment, and retention strategies are needed to attract new nurses to work in C/PH settings (1974, 2004). As I will discuss in Chapter 2, numerous research have addressed aspects of nursing experiences in the hospital and HH setting. Few studies have explored new nurse experiences in C/PH from the humanbecoming perspective. Qiao and Hu (2011) explored the experiences of graduate nurses in HH. The transition into the working world was

stressful because they lacked experience and confidence (Qiao & Hu, 2011). With the shortage issue worsening, it is vital to continue to explore ways to improve this unstable workforce. One study investigated the feeling of fear, but not in the nursing population (Baumann, 2009). My study used the humanbecoming theory to explore the meaning of feeling fearful as nurses entered C/PH settings.

Purpose of the Study

Baumann (2009) studied the feeling of fear for older adults, but few qualitative studies have explored feeling fearful for nurses entering C/PH. Exploring the meaning of feeling fearful will potentially accomplish the following objectives: (a) explicate the meaning of feeling fearful; (b) contribute to the understanding of the lived experience of feeling fearful for new nurses entering C/PH; (c) contribute to an extant body of knowledge by applying the humanbecoming paradigm as the nursing viewpoint, thus filling a gap in the literature; (d) create a platform for further research regarding new C/PH nurses. The purpose of this study was to explore the meaning of feeling fearful for new nurses working in C/PH settings.

Research Question

One question was presented in the qualitative descriptive exploratory method:

What is the meaning of feeling fearful?

“Parse’s humanbecoming theory adopted three principles which are structuring meaning multidimensionality, cocreating rhythmical patterns of relating, and cotranscending with possibles” (Parse, 1981, 2001, 2007, 2014, p.36). The research questions and

subquestions flowed from the three principles that served as the objectives and theoretical framework for this study. These objectives were:

1. To describe the significance of feeling fearful.
2. To describe rhythmical patterns related to feeling fearful.
3. To describe the concerns, plans, hopes, and dreams related to feeling fearful.

Objective One: To describe the significance of feeling fearful.

1. What is it like to feel fearful?

Objective Two: To describe rhythmical patterns related to feeling fearful

2. How does feeling fearful affect your routine?
3. How does feeling fearful affect your relationships?

Objective Three: To describe the concerns, plans, hopes, and dreams related to feeling fearful.

4. What are your concerns and plans?
5. What are your hopes and dreams?

Conceptual Framework

The theoretical framework for this study was the humanbecoming paradigm. Originally, Parse's framework was called *Man-Living-Health* (Parse, 1981, p. 4). Man-Living-Health has since evolved from the humanbecoming school of thought to the humanbecoming paradigm (Parse, 2007, 2014). The humanbecoming paradigm "is a worldview, a unique perspective about a phenomenon of concern to a discipline as well as a school of thought which "contains an ontology, epistemology, and methodologies" (Parse, 2014, p. 25). In this theory, a "human is a biopsychosocialspiritual organism and

health is a state of well-being, and in the simultaneity, the human is a unitary being and health is a value” (Parse, 2014, p. 25). Humanbecoming principles illuminate concepts with inherent paradoxes that demonstrate “a rhythmical shifting of views” (Parse, 2014, p. 35). As feeling fearful is explored, “linguistic and imagined content of something” and “moments from everyday living” shed light on this phenomenon (Parse, 2014, p. 33).

Creating a new conceptualization about feeling fearful will contribute to the knowledge base of the nursing discipline. The humanbecoming paradigm uses three objectives to describe the nursing perspective for this study from which the research questions flowed (Parse, 1981, 2007, 2014).

Nature of the Study

This qualitative descriptive study included an exploratory approach to investigate the meaning of feeling fearful. Use of an exploratory method facilitated discovery of “patterns and themes about life events retrieved through participant interview” (Parse, 2001, p.59). I selected 10 C/PH nurses to interview for this study. I gathered data via an interview protocol using open-ended questions that flowed from the humanbecoming objectives noted above (Appendix A). I analyzed the data that related to the conceptualization of feeling fearful and emerging themes were expressed through the humanbecoming frame of reference. Further discussion about the methodology of this study is in Chapter 3.

Operational Definitions

The following are definitions of key terms used throughout this study:

Advanced practice registered nurses [APRN]: A nurse who has completed an accredited graduate-level education program preparing her or him for the role of certified nurse practitioner, certified registered nurse anesthetist, certified nurse mid-wife, or clinical nurse specialist; has passed a national certification examination that measures the APRN role and population-focused competencies; maintains continued competence as evidenced by recertification; and is licensed to practice as an APRN (ANA, 2010, p. 63).

Community Health Nursing (CHN): a nursing specialty that focuses on the comprehensive care of patients in the community or public setting. This specialty includes HH, schools, occupational health, and numerous settings outside of the hospital (ANA, 2010).

Fear: the expectation or worry about something bad occurring. A physiological emotion ignited by real or imagined threat that causes one to fight or flee (Merriam-Webster, 2015; English & Stengel, 2010).

Graduate Nurse (GN): a nursing student who has recently completed all nurses courses and is eligible to take or has taken the nursing licensure exam (NCLEX-RN), or a professional nurse within 1 year nursing practice (Kramer, 1974).

Humanbecoming paradigm: a worldview about a phenomenon of concern to a discipline as well as a school of thought that “contains an ontology, epistemology, and methodologies” (Parse, 2014, p. 25).

Humanuniverse: Indivisible, ever-changing cocreation (Parse, 2014).

New Nurse: a nurse, community health nurse, or public health nurse within 2 years of nursing practice.

Public Health Nursing (PHN): a nursing specialty that focused on population health through health promotion and disease prevention and interprofessional collaboration that facilitates various levels of client systems in communities and population (Kulbok, 2012). For the purposes of this manuscript, Community/public health nurse will be used interchangeably as much of the literature continues to use the titles interchangeably (ANA, 2010; Kulbok & Ervin, 2012).

Registered Nurses (RN): a licensed nurse who is authorized by a state, commonwealth, or territory to practice nursing (ANA, 2010).

Skype: A free online service that provides an electronic medium through the computer, telephone, and webcam, through which face-to-face interviews can occur (Janghorban, Roudsari, & Taghipour, 2014).

Assumptions and Limitations

One of my major assumptions was that interviews would contain accurate information from participants and produce description-rich data regarding feeling fearful. To address credibility of the data, I interviewed participants until saturation of the data was accomplished. In addition, reading and re-reading the data for accuracy and listening to transcripts of the interviews repeatedly contributed to the trustworthiness of this study (Lincoln & Guba, 1985). Participants were offered several options to review the taped recordings and segments of the transcripts, also called member checking. Lastly, I assumed that new nurses would be eager to share their experiences about feeling fearful regardless of financial compensation.

This study was limited to 10 participants. A small participant size served the purpose of this qualitative descriptive inquiry, but does not provide data that are generalizable to all nursing populations. The qualitative descriptive exploratory method did not require a specific number of participants, since the goal was to explore lived experiences of participants. This study was not conducted to compare participants or generalize large amounts of data. Additionally, several studies used 10 to 25 participants in their studies and Parse supported using 10 participants to gather significant data to reach saturation (Parse, 2001; Baumann, 2009; Bunkers, 2016).

A potential weakness of this study was time constraints. More data would be available if the participants were interviewed at different phases of their nursing career. Interviews from new nurses at 2 years, 3 years, and 5 years would provide raw data that could provide comparison data of nurse's fear for each year. This information would provide valuable feedback to C/PH agency administrators, college faculty, nursing staff educators, and health care providers. Description rich data was obtained from 10 participants as noted by Hannes study (2011).

Scope and Delimitations

This study used a qualitative descriptive approach to investigate the meaning of feeling fearful. The participants were 10 new C/PH nurses working in a C/PH setting. My recruitment flier noted the inclusion criteria for participants (Appendix B). Each nurse was required to have a valid nursing license from a Board of Nursing for their practicing state. Due to the purposes of this study, only nurses with a baccalaureate degree in

nursing (BSN) were included. Thus, the findings from this inquiry could not be generalized across the nursing population.

Significance and Social Change

This study could facilitate dialogue among educators, administrators, and stakeholders about ways to improve the educational environment of nursing programs. C/PH professionals, healthcare stakeholders, and universities will have access to this information that will provide awareness of new C/PH nursing perspectives as they enter this area of nursing. Patterson et al. suggested that personal, relational, and systemic dimensions should be addressed to improve work experiences (2013). This study could facilitate sharing of new ideas to improve C/PH on a personal, relational, and systemic level. Additionally, this study gives voice to new C/PH nurses as they express what fear is like as they work in a new setting. Thus, implications for social change include an understanding of new C/PH nurses' perspective of feeling fearful as they enter the workforce. This study also facilitates the opportunity to explore creative ways to develop nonthreatening learning environments in nursing programs, residencies, and C/PH health facilities.

Summary

The literature has documented the difficulties of transitioning from nursing student to professional nurse. This period is marked with anxiety and fear (Sneltvedt et al., 2010). Studies about the transition of new nurses focused on the hospital setting. Minimal in-depth research has been conducted regarding fear and nurses as they

transition into the C/PH setting. In light of nursing shortages in C/PH, more information is needed to recruit and retain nurses in this field.

Such data could facilitate dialogue among nursing leaders and educators which may foster nonthreatening learning environments in nursing schools and nurse orientation programs. This study has the potential to set the stage for future research regarding feeling fearful. Because fear is a universal emotion, this study also has the potential to affect positive social change across disciplines (Shah, 2013).

The second chapter of this study will review historical and current literature gained from peer-reviewed studies and seminal publications. The following sections will summarize qualitative and quantitative inquiries about the foundational aspect of fear, C/PH, and HH nursing as it pertains to this study.

Chapter 2: Literature Review

Introduction

Nurses are entering C/PH earlier in their careers than ever before. A study by Sneltvedt et al. documented the challenges of HH nurses entering the work setting (2010). Graduate nurses are hired before graduation in some institutions (Ballem & Macintosh, 2014). The study by Ballem and Macintosh (2014) documented mixed feelings from staff as new graduates entered the hospital setting. Another trend was that nurses are changing careers after many years of working in a hospital. This is discussed later in the chapter. In my study, I explored fear and the experiences of new C/PH nurses through the humanbecoming theoretical lens. In this study, a new nurse is defined as an RN with zero to two years of work experience in C/PH. This study explored the meaning of feeling fearful and the population was C/PH nurses with 2 years or less C/PH experience.

This literature review includes studies about fear from a sociological, psychological, and educational perspective to provide a multifaceted view of this emotion and the effect it has on society and human beings. Additionally, in this literature review, I investigated the learning process and the humanbecoming framework related to fear and the feeling of fear as a phenomenon. Due to the limited studies found regarding feeling fearful and new nurses, this literature review was expanded to include fear as a related theme in nurse and graduate nurse experiences in various nursing settings with a focus on C/HH) nursing.

I conducted this literature review from current peer-reviewed studies surrounding the topic of fear in numerous disciplines. This study included inquiries about graduate nurses, nurses in C/PH, and HH settings from reputable nursing journals and various databases such as SAGE, EBSCOhost, Pro Quest, Ovid, Walden University Library Services, Perry Point Veteran Affairs Library, and Google Scholar. CINAHL Plus with Full Text, MEDLINE with Full Text, and the Merriam-Webster online dictionary were also used to identify additional resources and documentation related to fear and nurses. I obtained historical research about fear from seminal publications of classic works from Dewey, Parse, and Lupton to provide a historical foundation of fear and new nursing research.

The Phenomenon of Fear

Researchers have discussed fear as a deterrent to and facilitator for obtaining new knowledge or engaging in new experiences (English & Stengel, 2010; James, 2007; Dewey, 1910; Rousseau, 1979; & Freire, 2005). Additionally, fear is associated with “uncomfortable feelings” (English & Stengel, 2010, p. 522). Fear is ignited by a real or imagined threat that causes one to fight or flee (English & Stengel, 2010). Merriam-Webster describes fear as the expectation or worry about something bad occurring (2015). The remainder of this literature review is dedicated to the educational, sociological, psychological perspectives of fear, and the feeling of fear as it relates to the humanbecoming paradigm.

Physiology and Fear

A notable contribution to the literature on fear is the *Triangle of Fear* (Keane, 2001/2011). Keane describes fear as a triangle that includes *threatening objective circumstances, abreactions, and subjective symptoms* (2001/2011). Each angle of the triangle represents interrelated interactions that a person or group experiences at a given moment in time (Keane, 2001/2011). One side of the triangle is objective circumstances that a person perceives as threatening (Keane, 2001/2011). The other side of the triangle is the physiological and mental symptoms produced by fear. Lastly, the third side of the triangle is the “individual’s or group’s abreaction” (Keane, 2001/2011, p. 14). “The experience of fear is marked by physiological malfunction that is subjective to the individual. Fear and anxiety are differentiated in this thesis, noting that fear is acute in nature, and anxiety results from previous experiences. One person can become sweaty and nauseated while another becomes dizzy and faints because of fear (Keane, 2001/2011). Keane also noted that fear causes individuals to turn on others or stand frozen (2001/2011). Fear stifles mental capacity and originates from threats seen and unseen (Keane, 2001/2011). These manifestations of fear are external and are noted in the triangle of fear.

For nurses entering C/PH nursing, this emotion may have numerous origins. Keane’s study included triggers that ignite fear such as war, disease, and chaos. Each trigger could be a reality for C/PH nurses today. If fear has the potential to be a public problem of democracy, then fear can cause problems in the C/PH workforce.

Fear and Learning

Rousseau's approach to fear and learning was nonconventional, as he recommended exposing the learner to unpleasant phenomena as a means to foster learning (1979). This premiere philosophy posed that fear could be faced head-on, thus dispelling the expectation of an unpleasant encounter (Rousseau, 1979). One of the criticisms in Rousseau's study was placing a child in comfortable settings could provide a false sense of security, but would not provide a balanced process for dealing with fearful situations (Rousseau, 1979). Rousseau's approach was limited, as it encouraged more fear than learning (English & Stengel, 2010). Additionally, Dewey (1910) documented similar thoughts about fear and learning.

Dewey's phenomenological approach to fear and learning supported the notion that fear has its place in education, but should not be promoted as an integral factor (1910). Dewey researched educators as they discovered ways to create an environment that fostered interest in learning. In my study, fear was an unavoidable factor in the learning experiences of each C/PH nurse. Fear affected the participants in my study negatively and positively, yet each participant gained from their experiences. Dewey posited that fear translates into interest if the educator fosters interest in the learning environment (Dewey, 1997). This was true in some instances of my study and is documented in Chapters 4 and 5.

The Emotion of Fear

English, Stengel, and Freire defined fear as "a manifestation of being alive; life under conditions of oppression" (2010, p. 536; 2005). This emotion is neither "positive

nor negative;” it is a natural product of difficulty (English & Stengel, 2010, p. 536; Freire, 2005). Freire noted that fear becomes problematic when it is not dealt with constructively (Freire, 2005). Fear was addressed through reflections that lead to learning possibilities (English & Stengel, 2010; Freire, 2005). Facing fear requires a process that confronts the situation, identifies the fear, then commits to a social process of intellectual discipline (English & Stengel, 2010, p. 539; Freire, 2005). Freire defined the social process of intellectual discipline as a “social experience” that includes interactions “between teacher, learner, and among peer learners” (Freire, 2005, p. 538).

Pain and Smith investigated the premise that fear can be understood in a way that facilitates hope (2008). Fear can be devastating, affecting “personal, societal, welfare, commerce, the emotive, and the rational” (Pain & Smith, 2008, p. 300). The authors presented a geopolitical view that explains fear in light of terrorist attacks, political, and health epidemics. Pain and Smith (2008) suggested that there were new ways of dealing with fear that can be adopted by communities. As with any threat to global health, there is concern and fear among communities, individuals, and public health professionals that care for them. Fears such as exposure to illness, theft, and physical threat are emphasized in life through warning signs in public places and in the media (Pain & Smith, 2008). Medical media use fear to persuade communities to get flu shots and immunizations (Pain & Smith, 2008). The materiality of fear means, “there are tracks and traces between the different lives of those who seek to control fear and those whose lives are pervaded by it” (Pain & Smith, 2008, p. 587). Pain and Smith (2008), noted that fear can turn to hope through change in actions and behaviors. The conceptual framework in Pain

and Smith's study emphasized a connection of daily life to a larger geopolitical theme (2008). Additionally, fear analysis should be studied through the lived experience, thus leading me to humanbecoming (Pain & Smith, 2008; Shah, 2013, Parse, 2014).

This approach informed my qualitative descriptive study to explore the lived experience of feeling fearful for nurses entering public health nursing. Fear is unavoidable and the challenge remains with nursing educators, preceptors, and nursing supervisors to consider ways to harness this emotion in new nurses, thus using fear to benefit the learning process of new public health nurses.

Society viewed life through a lens of fear in the 21st century (Furedi, 2007; Keane, 2001/2011). Similarly, culture also played a major role in shaping individual perspectives of fear. Furedi noted that people had individual experiences of fear (2007).

Furthermore Lupton (1999) noted that fear could be expressed as anxiety, or uncertainty when faced with risky situations. This was noted in my study as participants' experiences with fear varied. Consequently, Duschler and Kramer studied the emotions of nurse graduates as they began nursing careers (Duchscher, 2009, Kramer, 1974).

Duchscher (2009) developed a framework called *transition theory*. The framework, transition theory, was used to evaluate nurse graduates as they acclimated to the practice of acute care nursing (Duchscher, 2009). Duchscher noted that fear, disorientation, and shock was observed as new nurses oriented to the acute care setting. Duchscher's 10-year study included the seminal work of Kramer's reality shock of 1974; coining the term *transition shock* (Duchscher, 2009). Implications of Duchscher's (2009) study posited that supervisors and communities should offer support to new nursing staff

as they transition from student to new nurse. Seasoned nurses were encouraged by management to foster relationships with new nurses to offer assistance and support (Duchscher, 2009).

Additionally, similar themes related to fear were found in the literature about nurse graduates. Researchers discussed “fear of making errors”, being unprepared, fear of others expectations, new work environment, bewilderment, lack of support, shock, and loneliness (Cho, Laschinger, & Wong, 2006; Duchscher, 2009, Kramer et al., 2013; Sneltvedt et al., 2010). Further, Pain and Smith (2008) supported the notion that fear expressed from the viewpoint of the victim yields rich information; the data from my study supported this premise.

Granger (2010), Shah (2013), Pain, and Smith (2008) contributed to the study of fear and chaos. Shah noted that fear is experienced by everyone and was created through numerous avenues (2013). Granger (2010) offered an artistic and theological perspective of fear as it relates to chaos from his background as a priest and drama/cinema artist. Granger’s work complemented the assertion that fear breeds chaos (Granger, 2010; Pain & Smith, 2008; Shah, 2013).

Similarly, Pain and Smith’s book was a collection of 16 articles that illustrated various origins of fear (Pain & Smith, 2008; Shah, 2013). The collection weaved a common thread of fear as it related to politics and various global manipulations (Pain & Smith, 2008; Shah, 2013). Fear breeds chaos, and individual reactions to chaos vary depending on the individual or the group experiencing fear (Pain & Smith, 2008; Shah, 2013). Moreover, Pain and Smith discussed fear created by states and organizations as

well (2008). Public health nursing is associated with political research, as C/PH nursing engages the fears of a community, state, or country when threat arises such as war or riots (Pain & Smith, 2008). With such societal situations, hope is the antidote to fear because it provides the possibility of a positive outcome in spite of a threatening situation (Pain & Smith, 2008).

Humanbecoming Perspective of Feeling Fear

In Kierkegaard's book, *Fear and Trembling*, the biblical account of Abraham and Isaac illustrated his faith in spite of fear. God tested Abraham's faith through a trial of trust. Abraham was told to sacrifice his son Isaac as a sign of devotion to God (Kierkegaard, 1843/1983; Arthur, 2013). Abraham was willing to kill his son to prove his devotion to God, thus he passed this test and his son was spared (Arthur, 2013). In this example, Kierkegaard illustrates that fear is an interweaving cycle of "love and faith" that is produced when people must make hard choices (1843/1983). Decisions in life require humans to weigh the risks of choices in relationships and the world in which we live (Kierkegaard, 1843/1983). Similarly, the humanbecoming paradigm by Parse promotes observations from the individual's perspective (Parse 2014, Pain & Smith, 2008).

The humanbecoming theory was applied to a study about feeling fear with a population of older adults (Baumann, 2009). Fear emerged as *haunting possibilities with cautious perseverance arising with reassuring affiliations amid defiance* (Baumann, 2009, p. 346). Baumann used Parse's phenomenological-hermeneutic method to discover the *structure of the lived experience of feeling fear* (2009, p. 346). Feeling fear from a humanbecoming perspective is "*discovered from situations that pose as a knowing threat*

to being; shown through living speaking-being silent, movement-being stillness, certainty-uncertainty that a threat to being cocreates, as the familiar is seen in new light” (Baumann, 2009, p. 347; Parse, 2007).

The conceptual framework of humanbecoming was used to explore fear. In my study, humanbecoming objectives were used to develop interview questions that addressed meaning, rhythmicity, and cotranscendence (Parse, 2001, 2014). New C/PH nurses working within two years of nursing practice were queried about feeling fearful.

Fear and New Nurses in Community/Home Health

Bunkers (2003) noted that fear is present in people’s lives as they work and engage with others. Fear is also relational; it involves what is occurring and what may happen in the future (Bunkers, 2003). Murray’s (1993) study about nurses entering CH stated that literature is lacking in research about graduate nurses and issues in the C/HH setting.

Further, this literature review was expanded to include graduate nurses in C/PH and various nursing settings due to the lack of research about new C/PH nurses. Kramer’s study about graduate nurses stated that nurse graduates of diploma, associate degree, and baccalaureate programs lack success in the working world. A nurse executive noted that they lack “self-confidence”, they fear their “own concept of inadequacy”. Fear has frozen their ability to function once they hit the floor and they are “scared to death of falling flat on their faces” (Kramer, 1974, p. 29). Similarly, new nurses found the transition into the working world stressful because they lacked experience and confidence. Thus my inquiry explored the meaning of feeling fearful as nurses anticipated entering C/PH settings.

New nurses struggled to adjust to the HH environment (Sneltved et al., 2010). Increased attention was given to the initiation of nurses in the HH setting. Sneltvedt et al. study provided insight from the experience of four new nurses working in HH care (2010). Moreover, studies by Ballem & Macintosh (2014), Sneltvedt et al., (2010), and Kramer (1975) noted the competence of nurse graduates as well as the environment in which they enter. The complexity of the patient population in HH caused anxiety in new nurses (Sneltvedt et al., 2010). Sneltvedt et al. study revealed themes such as “unexpected, surprising nurse role, responsible nurse role, thriving nurse role, and framework of the nurse role (2010, p. 263). Scheltvedt et al. stated that role change from student nurse to professional nurse was met with “certain fear and feelings of humility” in relation to the new role (2010). Additionally, Scheltvedt et al. noted that other feelings such as “feeling alone and unprepared” were noted but not expounded upon in the study (2010). These subthemes warrant further investigation in light of the data and the author’s summation that “they [nurse graduates] experienced fear of being inadequate” as well as lack of thriving in HH situations (Sneltvedt et al., 2010, p. 268). The Sneltvedt et al. (2010) study was limited to four participants, thus warranting more investigation of novice C/PH nurses entering C/PH for the first time.

Review of Methodology

A methodical review of the literature revealed a few quantitative and qualitative studies that focused on graduate nurse experiences in hospitals and C/PH settings (Sneltvedt et al., 2010; Sneltvedt & Sorlie, 2012). This portion of the literature review explored nurses who worked zero to two years in the C/PH nursing. At this time, few

studies regarding new nurses and feeling fearful exist. Themes surrounding fear and graduate nurses were discovered in the literature among HH nurses: the themes were fear of making a mistake, fear of failure, and fear of rejection (Sneltved et al., 2010; Sneltved & Sorlie, 2012).

An increased number of new nurses were hired by CH agencies in recent years (Patterson, Hart, Bishop, & Purdy, 2013). This phenomenological study noted the need for additional inquiry about the experiences of graduate nurses in HH (Patterson et al., 2013). The study by Patterson et al., (2013) documented interviews from eight new nurses who worked at two home care facilities. Participants held their first position in a HH facility (Patterson et al., 2013). The range of employment was 6 to 18 months and their ages ranged from 22 years to 37 years of age. One participant was male and seven were female (Patterson et al., 2013). Patterson et al. study did not focus on fear as a theme, but shed light on the experience of graduate nurses who chose HH as a first job (2013). Similarly, experiences of new HH nurses and new hospital-based nurses were similar, but major differences occurred when the new HH nurse was working independently in the community (Patterson et al., 2013). Patterson et al. (2013) illustrated three aspects of the work experience; they were personal, relational, and systemic dimensions of the work experience. Patterson et al. noted the need for longer orientation and preceptor programs for new nurses (2013). Patterson et al. also noted the need for further inquiry from the perspective of the new nurse in C/PH (2013).

Exploring fear as new C/PH nurses begin their career will be useful to students, new nurses, experienced nurses, educators, health care administrator, and stakeholders

who are concerned about community health. Sneltvedt and Sorlie included new nurses in the clinical and HH setting that focused on challenges for leaders and colleagues (2012). Sneltvedt and Sorlie included narratives of students working in nursing for the first time. Sneltvedt and Sorlie (2012) found that nursing leadership continues to struggle with ways to retain new staff. This generation of new nurses tended to be technologically perceptive and was an asset to the health community (Sneltvedt & Sorlie, 2012).

Summary

The literature supports the need for additional research and a deeper understanding of the nurses experiences as they begin working in C/PH settings. Kramer and Duchscher provided a foundation of research from which to build evidence supporting the need for improved orientation programs and preceptorships for new graduate nurses (Kramer, 1974, Duchscher, 2009). This information further illustrated a gap in the literature regarding documentation of new C/PH nurses experiences in the field. Studies regarding new HH nurses remain limited. Chapter 3 was the methodology section of this study. The details for how this study was conducted are discussed in the methodology chapter.

Chapter 3: Methodology

Introduction

The previous two chapters provided a general overview of historical and current literature surrounding the topic of C/PH nurses and situations they faced as they entered the nursing profession. A gap in the literature exists regarding the phenomenon of feeling fearful and new nurses entering C/PH. In this study, I explored the meaning of feeling fearful as new nurses entered the workforce of C/PH. In this chapter, I discussed the study's design and rationale, study questions, role of the researcher, ethical issues, data analysis, data collection procedures, coding, trustworthiness, discrepant cases, and dissemination of this study.

Research Question

What is the meaning of feeling fearful?

Objectives

1. To describe the significance of feeling fearful.
2. To describe rhythmical patterns of relating connected to feeling fearful
3. To describe the concerns, plans, hopes and dreams related to feeling fearful.

Research Sub-questions as Related to Each Objective

Objective One: To describe the significance of feeling fearful.

1. What is it like to feel fearful?

Objective Two: To describe rhythmical patterns of relating connected to feeling fearful.

2. How does feeling fearful affect your routine?
3. How does feeling fearful affect your relationships?

Objective Three: To describe the concerns, plans, hopes and dreams related to feeling fearful.

4. What are your concerns and plans?

5. What are your hopes and dreams?

Research Design

In this study, I employed a qualitative descriptive exploratory design that answered the question: what is the meaning of feeling fearful? Humanbecoming objectives provided the nursing perspective for this study regarding feeling fearful. They are listed here: to describe the significant of feeling fearful, to describe rhythmical patterns of relating connected to feeling fearful, and to describe the concerns, plans, hopes, and dreams related to feeling fearful.

The qualitative descriptive method originated from the social sciences and is useful for studying a phenomenon that progresses through patterns and themes about life events that facilitate answers to the research question (Parse, 2001). Parse's approach investigated the meaning of a life event for a group of individuals (Parse, 2001). The qualitative descriptive method is based on the following assumptions:

1. Humans create social networks.
2. Humans can describe retrospective and prospective life events.
3. Patterns and themes surface through intense study of phenomena. (Parse, 2001, p. 57).

Ten C/PH nurses with zero to two years of nursing practice volunteered for this study. A small participant size facilitated in-depth inquiry of feeling fearful. The

qualitative descriptive method does not require a specific number of participants since the goal is to explore the lived experience of participants. Several studies used 8 to 25 participants, and Parse supported using 10 participants to gather significant data to reach saturation (Baumann, 2009, Bunkers, 2016, Drummond 2012; Parse, 2001). The sample size of 10 is documented in the literature as a feasible number of participants to yield rich data and reach saturation (Hannes, 2011).

I recruited graduate nurses from various HH agencies from the East Coast and surrounding areas as noted in Chapter 1. Creswell (2013) noted that purposeful and snowball sampling were appropriate strategies to acquire participants for a qualitative study. Therefore, I employed purposeful and snowball sampling as recruitment strategies. These strategies provided access to participants who understood and experienced the phenomenon of fear. Inclusion criteria are outlined in this chapter and in the IRB application.

The participants were interviewed face-to-face and by telephone. Janghorban, Roudsari, Taghipour (2014), and Piela (2015), noted that when face-to-face interviews are not possible; telephone interviews are viable ways to gather data. Informed consent was obtained from all participants before conducting this study. Interviews were completed, transcribed, coded, and fully analyzed by me and approved transcribers. Participant transcripts along with rich descriptions yielded themes that were synthesized into the findings for this study. The participant's descriptions illustrated their perspective of feeling fearful.

Few studies were found regarding feeling fearful. Consequently, Baumann's study of 10 older adults explored feeling fear using the humanbecoming paradigm (2009). Baumann noted that "fear is universal and shapes the lives of individuals across the lifespan" (2009, p. 346). Baumann's study led to a new way of looking at fear and anxiety as compared to existing ways nurses examine these terms (2009). Baumann's (2009) study revealed the significance of feeling fear as it related to quality of life. Similar to Baumann's study, three objectives guided my research questions from a nursing perspective using the humanbecoming theory. Furthermore, a quantitative approach requires objectivity and yields predictable outcomes that can be measured (Creswell, 2009). This study required a qualitative approach that explored the lived experience. However, Creswell noted quantitative research uses numbers to qualify variable measurement and does not fulfill the needs of this study (2009). Parse (1981), noted in quantitative inquiry, data are analyzed using statistical processes and represents the outcomes of the quantitative study. Eide and Kahn (2008), and Creswell (2009, 2013) stated that experimental or survey results are expressed in numerical data that supports a proposed hypothesis. Further, Eide and Kahn (2008) noted that qualitative descriptive method required a vantage point that is shared by the researcher and participant that yields unpredictable actions, meaning, and discovery (2008). Thus, I employed the qualitative descriptive method for my study.

Rational for Research Design

This study adopted the qualitative descriptive exploratory approach from the humanbecoming frame of reference. This approach fit my study best because human

experiences require understanding from the participant's point of view. This is the focus of the humanbecoming perspective (Parse, 2001). Sciencing is an approach to inquiry that is systematic yet accomplishes the goal of exploring human experience as "ever-changing" (Parse, 2001, p. 1). Participants in this study were asked to describe feeling fearful in "concrete language" which is "gradually transposed into abstract language of science" (Parse, 2001, p. 4). This process was accomplished through the humanbecoming framework in a qualitative descriptive approach.

I considered a number of qualitative approaches for this study. One design was the narrative approach. The narrative study documents experiences through stories of individuals or groups (Creswell, 2013). The stories can be documented through a group of individuals or one person. Storytelling can be used to illustrate phenomena while using letters or photographs to visualize the experience (Creswell, 2013).

However, the narrative approach was not the best choice for my study. Parse noted feeling fearful was best explored from the perspective of the participants of an individual or group as described in the qualitative descriptive method (2001, 2014). Parse stated that the qualitative descriptive approach was guided by specific objectives which facilitated the meaning of a phenomenon, not merely stories of activities (2001).

Next, I considered the case study. This qualitative approach investigates extensive details about a "program, event, activity, or one or more individual" (Creswell, 2009, p. 13). Case studies are labor intensive and require time to process data and analysis. A case study would not facilitate the purposes of this study. Furthermore, time constraint and funding would pose a hindrance to the completion of this inquiry.

Grounded theory seeks to uncover theories and processes. This theory uses numerous designs and comparisons of data which is categorized and requires sampling of various groups (Creswell, 2009). The goal of my study was not to develop new theories, but to explore the phenomenon of feeling fearful, thus grounded theory was not appropriate.

Ethnographic studies are another way to explore everyday experiences. This unstructured approach to research is useful in discovering meaning of a phenomenon about cultural groups (Parse, 1985). This anthropologic process requires the researcher to live the experience alongside participants in their natural setting. This was a determining factor in my choice not to use this method of inquiry. Due to time consuming fieldwork, cost, and purpose of this study, this method was not chosen. The objectives of my study were met best through qualitative descriptive exploratory method.

Role of the Researcher

One of the hallmark tools of a qualitative inquiry is the interview (Janesick, 2011). Interviewing is a tool that requires practice by the researcher. Interviewing is defined as “a meeting of two persons to exchange information and ideas through questions and responses, resulting in communication and joint construction of meaning about a particular topic”, (Janesick, 2011, p. 100). Thus my role in this study was research instrument. Therefore, I studied feeling fearful from the humanbecoming perspective as posited by Parse (2001). According to Creswell, I collected data through observations, interactions with participants, and reviewing documents in accordance with (2009, 2013).

Additionally, the researcher's role includes primary investigator and data collector. Thus, interviews were set up according to the participant schedule. I conducted telephone interviews due to the distance of the participants.

Further, researchers run the risk of losing data when conducting studies in familiar settings as familiarity alters new perspective (Burns & Grove, 2005). Burns and Grove recommended being objective to some degree, and handling situations that arise quickly to avoid future ethical issues (2005). Consequently, the request to interview school nurses in a local county was denied, thus all participants were from areas unfamiliar to this investigator.

Furthermore, having supervised CH nurses provided me with a familiarity of issues that C/PH nurses experience. Because my experiences were over 5 years ago, I was objective as I listened to the participants. Journaling my thoughts assisted this process. Participants were recruited from institutions that I did not work for, thus there was no conflict of interest.

Ethical Issues

The Institutional Review Board #03-16-16-0266728 (IRB) was approved by Walden University to minimize ethical issues. The expiration date for my IRB approval was 03-16-2017. Guidelines were useful for protecting the rights of all participants. Issues addressed through IRB included the validity of the study, beneficence, special populations, and informed consent. Several processes were implemented to protect participants during this study. First, the participants were not an at risk population, thus special considerations were not needed. Participants were over 18 years of age and spoke,

read, and wrote English. All participants lived and worked in cities and states other than my own. Participation in this study was voluntary, risks were explained, and no coercion was used. Participants could leave the study at anytime during research and were informed of this before signing the consent form. Informed consent was employed and each participant verbalized understanding of the consent form and signed a copy. Consent forms were emailed to me and protected via password. Risk factors were included in the consent form as well as resources to provide counseling or immediate assistance, and were approved by IRB. The participants were given the option of Skype/telephone interviews or face-to-face interviews. Full disclosure of study requirements was outlined in writing, including time commitments throughout the study. Consent forms, the interview questions, and other forms to protect participants. I provided the nurse participants with a list of reputable resources from for C/PH professionals, and counseling for nurses. The resources were from free online counseling services, the Suicide Prevention Hotline, the Crisis Call Center, and Network of Care.

All IRB guidelines were honored and participant identities were protected at all times during this study. Data associated with this study were stored electronically and protected by passwords. IRB requires data to be stored for a minimum of 5 years, such data will be securely stored electronically and protected via password and/or locked file.

Data Analysis

The analysis format for this study was based on a qualitative descriptive exploratory approach. As posited by Parse, Coyne, and Smith, data were analyzed through the analysis-synthesis model, as described in Chapters 1 and 5 (1985). A coherent study involves specific steps that guide research in an exploratory method (Parse et al., 1985). As suggested by Creswell and Parse et al. participants were chosen through purposeful sampling. Data was collected and analyzed as outlined below per Parse (1985, p. 59)

- participant protection of rights, via IRB protocol
- gathering data through open-ended questions
- interviewing participants
- ensuring objectives and questions are compatible with the research purpose
- coding data
- analyzing-synthesizing data
- data saturation through reading and re-reading of the interview transcripts
- constructing a description of the phenomenon from a synthesis of the themes in the language of the participant and the language of the researcher
- moving the descriptive statement up levels of abstraction to the level of science in the discipline

Parse et al. (1985) methodological standards required the process of participant selection, and data analysis to be consistent with qualitative research. This study incorporated a qualitative process based on integrative criterion. Parse et al. (1985) emphasized including clear and consistent processes in all phases of research. In this instance, the study should identify with the theory and each part of the study should be congruent with all other aspects of the research (Parse et al., 1985). The sample size of 10 was documented in the literature as a feasible number of participants to yield rich data and reach saturation (Baumann 2009, Hannes, 2011). As noted previously, the qualitative descriptive method does not promote a specific number of participants (Parse, 2001). Data analysis was continued until theoretical saturation was achieved (Simon, 2011).

Access to Participants

Participant access was multifaceted. Recruitment included several C/PH agencies in urban and rural areas along the East Coast, there were 10 new nurses selected. Participants were recruited by contacting nursing graduates, professors, and supervisors. One community partner posted information regarding my study in an online closed nursing community.

An informational flier was provided for professors, colleagues, and agency supervisors to inform staff about the study (Appendix B). Contact with participants was limited to one interview to accommodate their busy schedules. Participants were aware of this process through informed consent. Additionally, Skype was offered as an alternative means of interviewing the participants. Skype is “a free synchronous online service” electronic medium through computer, phone, or webcam (Janghorban et al., 2014).

Unfortunately, Skype access was prohibited as some participants were interviewed while at work which limited connectivity to Skype. All participants were interviewed by telephone.

Furthermore, Piela (2015) suggested setting up a test session prior to the interview sessions, consider the researcher/participant surroundings and location for the interview, and plan for exiting the interview and participant contact. Therefore, questions were asked at the start of each interview to check sound quality and facilitated any questions from the participant. The transcript for the sound check questions was “Hello (participant name) let’s do a voice check to make sure our connection is good”. “Please speak your name and credentials”. “Thank you”. Piela recommended testing the connection before beginning the interview.

Data Collection Procedures

Researcher-Participant Relationship

I interviewed the participants using an interview protocol that was based on the humanbecoming paradigm. Parse gave me permission to use the interview questions and the instrument was approved by IRB. Criteria for inclusion was as follows:

- at least 18 years of age, English speaking, able to read and write English
- a graduate of an accredited bachelor’s degree nursing program
- new nurse working in the C/PH setting within two years
- participant must read and sign a consent form to enter this study

Emphasis was placed on confidentiality and full disclosure of possible risks and benefits of the study were presented via the consent form. As compensation for study

participation, I provided an honorarium of a \$5 gift card. The consent form stated that a \$5 money card would be given to the participant for participating in the study.

Participants were aware that they could withdraw from the study at any time, thus establishing trust between the researcher and the participant (Jansick, 2011).

Instrumentation

The process that provided the foundation for the research instrument is based in the qualitative exploratory descriptive approach. An exploratory approach seeks the “meaning of a life event for a group of people” (Parse, 2001). Questions were based on the humanbecoming objectives which framed open-ended questions of the interview protocol (Parse, 2001). Data was obtained through this interview protocol (Appendix A). The interview protocol was applied to the phenomenon of study: what is the meaning of feeling fearful?

The objectives were:

1. To describe the significance of feeling fearful.
2. To describe rhythmical patterns of feeling fearful.
3. To describe the concerns, plans, hopes and dreams related to feeling fearful.

The research questions flowed from the objectives using similar verbiage and/or having the same meaning as the objectives (Parse, 2001).

The data analysis process for this study is called data analysis-synthesis. “This is the process of moving the descriptions from the language of the participants across levels of abstraction to the language of science” (Parse, 1987, 1996, 2001). In this process, data are gathered from transcripts, art, or music, and may be used to describe the phenomenon

(Parse, 2001). Other studies that have used the humanbecoming instrument and model are Parse (1996) and Ma (2014) regarding quality of life, Baumann (2009) in a study about fear. Other studies using the humanbecoming instrument are noted in Chapter's 4 and 5.

Coding Data

The data analysis process for this study was based on a qualitative descriptive exploratory approach. Data was analyzed through the data analysis-synthesis model (Parse, et al., 1985, Parse, 2001). A coherent study involves specific steps that guide research in an exploratory method (Parse et al., 1985). "Data gathering and data analysis-synthesis are interrelated processes" and are carried out simultaneously (Corbin & Strauss, 1990, Parse, 2001, p. 37). Additionally, gathering data also leads to coding, memoing, and seeks new data (Strauss, 1987, Parse, 2001). Thus coding was incorporated in this process.

Open coding was conducted manually to compare similarities and differences of "events/activities/interactions" of all participants (Strauss, 1987; Parse, 2001, p. 38).

"Interpretation of the findings is to be done in light of the original conceptualization and requires connecting the identified themes to the discipline-specific frame of reference and elaborating on the new knowledge gained from the study" (Parse, 2001, p. 59). Consequently, Microsoft Word software was used to assist with identifying themes from each transcript. NVivo was not used because it was not appropriate for the analysis-synthesis process (Creswell, 2009; NVivo, 2014).

Verification of Findings

Verification and trustworthiness are vital elements of rigor in scholarly writing (Rudestam & Newton, 2007, Sieber, 1992; Simon, 2011). The literature also stated that credibility is established through sound research that contributes to ongoing research (Parse et al., 1985). To establish credibility in this study, trustworthiness was established through credibility, dependability, transferability, and confirmability (Lincoln & Guba, 1985; Jansick, 2011; Simon, 2011).

Credibility

Member checking, data saturation, and participant quotations established credibility for this study. Participants were informed of member checking options. Carlson (2010) documented member-checking options for participants to choose. This technique is 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 (Hannes, 2011). This was accomplished through member checking.

Each participant was offered to review the audio taped recordings and my notes at the end of their interview. Participants listened to their recordings and was given the opportunity to make changes or add information. I listened to all audio taped recordings and transcribed each interview until no new data was discovered. IRB approved transcribers reviewed and transcribed two interviews. Credibility was also established through saturation in the data (Morse, 1994; Denzin & Lincoln, 1994; Lincoln & Guba, 1985). Direct participant quotes were used in the data analysis process (Morse, 1994; Denzin & Lincoln, 1994, Jansick, 2011; Lincoln & Guba, 1985).

Member checking can be problematic if participants disagree with the researcher analysis or transcripts (Morse, 1994; Denzin & Lincoln, 1994). It can also be overwhelming to ask participants to review large amounts of data. Because the participants lived far away from me, various options for member checking were offered to accomplish this verification. Participants were informed how their data would be used which increases confidence in the researcher (Carlson, 2010). Participants listened to their recorded interviews, reviewed researcher notes taken during the interview. Each participant was offered to review portions of the transcribed interview, and obtain access to the published dissertation (Carlson, 2010). Each participant chose to listen to their taped recording and verbal review of the researchers' notes. One participant requested a copy of the researcher's notes that was provided via email. Each participant will be provided with a link to the published dissertation. This study employed the use of direct quotations, in addition to repeated listening and re-reading of the data (saturation) during the analysis process to establish credibility (Morse, 1994; Jansick, 2011; Lincoln & Guba, 1985). Participants and the community partner will have the opportunity access to a final copy of the study (Morse, 1994; Denzin & Lincoln, 1994; Jansick, 2011).

Dependability

The flow of a research study is assessed through dependability evaluation techniques. Such processes like audit trails and reflexivity substantiate dependability (Hannes, 2011). This study used an audit trail and reflexivity to accomplish this assessment. The audit trail was documented in the data analysis process in Chapter 3. It is imperative to have a detailed approach to qualitative analysis to ensure a scientifically

sound study (Lincoln & Guba, 1985; Parse, 2011). This cohesion was accomplished by following detailed steps illustrated in each phase of the qualitative descriptive outline (Parse, 2011).

Further, reflexivity was used through reflexive writing in a personal research journal (Lincoln & Guba, 1985). Triangulation was used to assess studies by obtaining data from different sources (Simon, 2011; Creswell, 2013). Data was obtained from audio-recordings, notes, and transcripts of the participants.

Transferability

Evaluation of transferability in research includes documenting details of the participants such as demographics, background information, thick description of data, and the inclusion process (Hannes, 2011). Details of participant demographics, and work experience are documented in Chapter 4. Thick description of the data was obtained from participant interviews and transferred through verbatim transcripts (Hannes, 2011). Every effort was made to maintain participant confidentiality throughout this study by following the criteria outlined in the Institutional Review Board (IRB). No personal names or personal demographics was assigned or shared throughout this study. Pseudo-names was used for each participant. Any personal data was stored via password protection and or locked files as outlined in IRB. Information will be stored for five years per IRB approved methods.

Confirmability

Techniques for establishing confirmability included reflexivity and researcher self-evaluation of bias, experiences, and background (Hannes, 2011). Biases such as

research beliefs and values should be documented. Creswell (2007) recommended self-reflection to illuminate personal feelings surrounding a phenomenon. A good study will include thoughts from the researcher about their background, culture, and any personal issues that could color research findings (Creswell, 2007; Burns & Grove, 2005). This was documented in Chapter 3.

Reflexivity contributes to confirmability and was discussed earlier in this study. Lincoln and Guba (1985) also noted this type of recording methodological decisions and the rationale for reflective writing; logistics of the study, and reflection upon what is happening in terms of one's own values and interests. My background information will be documented appropriately in this study.

Handling of Discrepant Cases

Minimal problematic discrepancies were anticipated in this study. The goal was to interview 10 new nurses in C/PH nursing. This group was homogeneous regarding career and experiences. There were no conflicts of interest since no participants worked in my county. Participation was voluntary and withdrawal from the study could occur at any time during the study. Participants will be recruited until the optimal number and saturation was obtained. Guidelines were implemented in this study to decrease potential problems. These guidelines included: recruiting participants that I did not know or work with, have an in-depth understanding of my topic, spend extended time reviewing the data, and allow participants access options to member check data for verification (Carlson, 2010; Janesick, 2011). I provided close attention to detail at each stage of this study to decrease the probability of issues occurring as the study progressed. All data was

secured electronically via password or kept in a locked file. Access to data was restricted to authorized persons, and all transcribers were approved during IRB. Letters of agreement, an invitation flier, and letters of participation are documented in the Appendix of this study.

Dissemination of Study Findings

One of the “rites of passage” into the academic arena is dissemination or publication of the dissertation. The first step is presenting the dissertation to my chair and committee during the oral defense (Rudestam & Newton, 2007). Another avenue will be through my community partners and participants who will have access to this study. I am associated with a number of universities, Nurses Associations, Sigma Theta Tau, and The Humanbecoming Institute which provide opportunities to disseminate this study. Journals such as SAGE, Public Health Journal, and publications through the Veteran’s Administration provide opportunities for dissemination of new studies. It is my hope to increase the awareness of fear in the graduate nurse population as they enter C/PH, thus facilitate safe and nurturing environments in the workplace for all nurses and their patients.

Summary

This proposed study explored the meaning of feeling fearful. The population was graduate nurses within their first two years of practice in C/PH nursing. The approach was a qualitative, descriptive method that documented the experiences of 10 participants from the perspective of a humanbecoming framework.

The methodology chapter provided details of this study's design, rationale for each decision made regarding the study, role of the researcher, and specific steps for conducting the study. The primary question for this study is:

What is the meaning of feeling fearful? The humanbecoming paradigm is the nursing perspective through which objectives and questions facilitated during the data gathering process. New nurses with zero to two years of experience in the C/PH setting were recruited for this study.

In this chapter I documented the methods of assessment from which trustworthiness will be established. The appendix section of this document includes the interview questions, the recruitment flier, the transcriber's confidentiality agreement, participant consent form, community partner agreement, and consent to release manuscript for publishing form. The aim of this study was to fill a gap in the literature regarding feeling fearful for graduate nurses as they enter the field of C/PH nursing. This study also described a contingency plan to resolve discrepant cases and problematic issues as the study progresses.

Next, this study documented the process used to gather, document, and analyze data produced in this research. This study also provided the outcome of the data analysis. The IRB approval number assigned for this study is 03-16-16-0266728.

Chapter 4 will provide details of the data collected from participants in this study. Microsoft Word software was used to organize raw data, assist with coding, and manage all data. A journal was kept to record my reflexive information and data analysis process throughout. The detailed steps are outlined in Chapter 3 and served as my audit trail.

Chapter 4: Results

Introduction

Demand for C/PH professionals continues to increase; yet the nursing workforce in this field is plummeting (Young, Acord, Schuler, & Hansen, 2014). This dilemma has global ramifications. “A sound public health system is the most important determinant of good health in every country in the world” (Young, Acord, Schuler, & Hansen, 2014, p. 566). However, there continues to be a gap in the literature regarding new C/PH nurses.

For this study, I used a qualitative descriptive exploratory design that answers the question: What is the meaning of feeling fearful? I recruited and interviewed 10 graduate C/PH nurses this study. Approval for this research was obtained through Walden University’s IRB (IRB #03-16-16-0266728). This study will potentially (a) explicate the meaning of feeling fearful, (b) contribute to the understanding of the experience of feeling fearful for new nurses entering C/PH settings, and (c) contribute to an extant body of knowledge using the humanbecoming paradigm, thus fulfilling a gap in the literature. In this chapter, I cover the findings of this study and present the setting, demographics, data collection, data analysis, evidence of trustworthiness, discrepant cases, results, and conclusions.

Setting

For this study, I interviewed 10 C/PH nurses from seven health facilities and two schools located along the East Coast. States represented in this study included Maryland, Virginia, New Jersey, and Pennsylvania. C/PH facilities were located in rural and urban

communities. All participant supervisors were agreeable to staff participation in this study.

Demographics

Participants for this study were new to C/PH nursing. C/PH experience ranged from 2 to 24 months. Number of years as an RN ranged from 2 to 33 years. Demographic data was limited to protect the identity of the participants and the places they worked; thus data included number years of work experience in nursing and C/PH, nursing credentials, and area of practice. I recruited 10 of the 12 volunteers for this study. Before the consent form was signed and returned, volunteers were given the opportunity to ask questions about the study. Potential participants agreed to the terms of the study, all questions were answered, and each consent form was signed and returned to me. Each participant lived or worked in another geographic area than myself, thus face-to-face interviews were not feasible. Below is a description of participant demographics:

- Time as C/PH Nurse
 - Three nurses with 0 to 6 months experience
 - Three nurses with 9 months to 1 year
 - Four nurses with 1 and 1/2 to 2 years
- Time as RN
 - Three nurses with 2 to 3 years as an RN
 - Four nurses with 4 to 6 years as an RN
 - Three nurses with 20 to 33 years as an RN
- Specialty

- Two school nurses
- Eight C/PH nurses

Data Collection Procedures

Recruitment for this study began on April 11, 2016 and ended on June 10, 2016. One community partner was selected and approved via IRB. Participants were recruited via face-to-face encounters, email, and telephone. Twelve volunteers were contacted, two were interviewed face-to-face, but did not meet the criteria for inclusion in the study. One volunteer had too much nursing experience in community health. Another nurse worked in a facility that did not fit the study's criteria. Thank you gifts were given to the two volunteers for their time. I recruited and interviewed 10 new C/PH nurses for this study. Each participant was screened according to the criteria described in Chapter 3 and outlined in the IRB approved document. Participation was voluntary and informed consent was obtained from each participant. Pseudonyms were assigned to each participant and confidentiality was maintained as approved by the IRB. Participants were interviewed once via telephone. Interviews lasted approximately 15 to 20 minutes. Time was allotted for member checking at the conclusion of each interview. Participants were given several options for the member checking process. A formal structured interview tool was used that consisted of six open-ended questions. Permission to use the interview tool was obtained before IRB approval. Each interview was recorded via iPad and iPhone applications and protected with passwords. Field notes and interview transcripts were stored on a Mac computer and password-protected files, and printed data was stored in a locked file box. This information will be stored for 5 years per IRB protocol.

Compensation for study participation was a \$5 dollar gift card per IRB recommendation. Participants were informed before the study that they may withdraw at anytime. Twelve participants were interviewed in all and 10 fit the inclusion criteria and were selected for the study. There were two discrepant cases for this study as explained above.

Data Analysis

The data analysis process for this study was based on a qualitative descriptive exploratory approach. Coding and the data analysis-synthesis model were indicated for this study (Parse et al., 1985; Strauss, 1987). I conducted manual coding and analysis-synthesis based on this information. I transcribed the audiotaped recordings verbatim along with two approved transcribers per IRB instructions. I reviewed the audiotaped recordings multiple times and transcripts were re-read for accuracy. I reviewed all transcripts along with audio taped recordings to discover any new data. All field notes was compared to the date throughout the analysis process.

Coding

As suggested by Strauss (1987) and Parse (2001, p. 38), open coding was conducted manually to compare similarities and differences of “events/activities/interactions” of all participants.

As recommended by Tesch, I used a combination of the following processes to code the data (1990). Microsoft Word software was used to organize and code data (pp. 142-145). First, I reviewed all transcriptions verbatim, and took notes continuously. I typed all interviews in a Microsoft Word document. I kept notes in a research journal. I dissected each interview line by line. Then, I began the open coding process by using

“track changes” to label data. Each code was ascribed meaning to facilitate further grouping into themes. Potential themes were clustered by similar topics manually in columns, then in boxes. Data were reviewed again checking for any new topics.

As I reflected and reviewed each list multiple times, I reduced my list into categories by grouping related themes; I used the lists that progressed to smaller tables of coded data. Themes were developed and assigned to coded categories after reviewing them numerous times. A preliminary analysis was conducted and this process was repeated as needed. Recoding continued until lists of themes were developed and no new themes were discovered. This process is noted in tables 1 through 4.

Themes and pre-data analysis and synthesis

Objective One: Meaning-To describe the significance of feeling fearful.

Q1. What is it like to feel fearful?

Table 1

Codes from Objective One

Codes	Themes
Anxiety, confusion, overwhelmed.	Q1 EMOTIONS OF FEAR
Terrifying. not knowing what to do. Different from what I know. Adjustment. Scary.	EXPERIENCES OF FEAR
Constant, different. failure. different stress, different fear.	PEOPLE EXPECTATIONS OF FEAR
Uncomfortable, out of your element. Fearful with people and in homes alone. Different type of nursing from before.	FEAR OF THE UNKNOWN
Anxiety, stress, not fearful	
Constant, different, failure. Different stress, different fear.	
The unknown, excitement. People expectations. I don't want to talk about it.	
Doing it wrong, independent role	
No balance. Lack of structure.	
New to PH. No training, not knowing what to do. Scary	

Objective Two: To describe patterns of relating connected to feeling fearful.

Q2. How does feeling fearful affect your routine?

Q3. How does feeling fearful affect your relationships?

Table 2

Codes from Objective Two

Codes	Themes
Throw me off track, unable to prioritize, anxiety, difficult to communicate	Q2 THEMES
Throws me off, nervous.	THROWS ME OFF
Not being prepared. Being a mean person.	LEARNING THE JOB AND MY ROUTINE
Needed more help from others. Family wanted you safe. Timid with first patient visits	ROLES AT MY JOB
Doubting self. Reached out for help.	
Strengthened my relationships.	Q3 THEMES
Not knowing anyone at first.	STRENGTHENS MY RELATIONSHIPS
Acceptance from peers, how they perceived me.	
Hiding who I really am.	PERCEPTIONS OF OTHERS
Depending on my peers for help. Lack confidence.	PARTNERSHIPS AND SUPPORT
Anxious and slower. Perception of my peers.	ASPIRATIONS

Objective Three: To describe concerns, plans, hopes, and dreams related to feeling fearful.

Q4. What are your concerns and plans?

Q5. What are your hopes and dreams?

Table 3

Codes from Objective Three

Codes	Themes
Less fear as I gain more experience. Less anxiety. Happy.	Q4. EXPERIENCE REDUCES FEAR
Throwing you off, having help, more confidence. Support, controlled fear.	SUPPORT HELPS ME
Teamwork, confidence. Rewarding to help people.	Q5. AUTONOMY AND PROMOTION
Learned a lot, have a better perspective.	EMPOWER OTHERS AND THE COMMUNITY
Meaningful work to do. Future full-time employment. Increased autonomy.	COLLABORATE WITH OTHERS
Impact people, better healthcare for the United States and youth. Role models for youth.	HAPPINESS/REWARDING CAREER
Empower the community.	
Provide the best care, keep learning. Adults and children are successful.	
To be promoted and stay in PH nursing.	
Keep learning. Improve communities, control fear that is always there. I don't want to leave because I did something wrong.	

Table 4

Core Concepts Across Levels of Abstraction

Core Concepts	Structural Transposition	Conceptual Integration
Disquieting unease arising with the unforeseen	Distressing apprehension arising with not-knowing	Imaging, valuing, linguaging
Unpredictable affiliations surfacing amid diverse encounters	Affirming-non- affirming relationships surfacing with work-day engagements	Revealing- concealing Connecting- separating
Pondering possibilities arise with potent assuredness	Creative formulating arises with gaining a confident perspective	Powering Originating Transforming

As noted in the tables above, the manual process of coding provided a preliminary coding of the data. Selective coding was also employed to determine new data within the three objectives (Strauss, 1987, Parse, 2001). This pre-analysis was instrumental to making linkages among discovered concepts, leading to conceptualization of raw data (Strauss, 1987, Parse, 2001). The detailed coding process noted above continued as needed.

Thirteen themes were discovered via this process.

Further review of the audiotape recordings and re-reading of the transcripts was necessary to progress to the analysis-synthesis of the data. The data was analyzed and synthesized into themes “according to the study’s objectives in the language of the participants and in the language of the researcher” (Parse, 2001, p. 59).

Interpretation of the findings was done in light of the original conceptualization, thus connecting the identified themes to the discipline-specific frame of reference (Parse, 2001, p. 59). The findings are presented in the following manner:

- Themes which surfaced from the participant descriptions as they relate to the questions of each objective.
- Participant’s descriptions of feeling fearful with participant quotes.
- Participant’s synthesized statements written in their own language according to each objective.

The final description answers the question, *what is the meaning of feeling fearful for new community/public health nurses?*

Themes

Participant descriptions are synthesized into statements and divided according to the objectives. This analysis produced themes in relation to three objectives. The researcher identified major themes, yielding the findings of this study. The themes that originated from the data are stated below in participant language and researcher language.

Language of the Participants: Feeling fearful is distressing apprehension arising with not-knowing, affirming-non-affirming relationships surfacing with work-day engagements, as creative formulating arises with gaining a confident perspective.

Language of the Researcher: Feeling fearful is disquieting unease arising with the unforeseen, unpredictable affiliations surfacing amid diverse encounters, as pondering possibilities arise with potent assuredness.

Objective One: To describe the significance of feeling fearful.

Table 5

Obj. 1 Participant and Researcher Language

Language of the Participants	Language of the Researcher
Feeling fearful is distressing apprehension arising with not-knowing.	Feeling fearful is disquieting unease arising with the unforeseen.
Objective (Obj).	

Objective Two: To describe the rhythmical patterns of relating connected to feeling fearful

Table 6

Obj. 2 Participant and Researcher Language

Language of the Participants	Language of the Researcher
Feeling fearful affirming-non-affirming relationships surfacing with work-day engagements.	Feeling fearful is unpredictable affiliations surfacing amid diverse encounters.

Objective Three: To describe the concerns, plans, hopes, and dreams related to feeling fearful.

Table 7

Obj. 3 Participant and Researcher Language

Language of the Participants	Language of the Researcher
Feeling fearful is creative formulating arises with gaining a confident perspective.	Feeling fearful pondering possibilities arise with potent assuredness.

Results

Participant's Descriptions

This section includes participant descriptions followed by themes and synthesized statements in participant language. The themes are organized according to each objective.

Ruby's Description of Feeling Fearful

Ruby is a 4 year nurse with 1 year 8 months experience in Community Health Nursing. Ruby said, “to feel fearful is to me would be to produce feelings of anxiety, confusion, feeling overwhelmed”. She felt “those feelings can throw me off of my routine if I don’t have a sense of what I need to do”. Ruby is not new to nursing and was confident in her previous job. Yet, she felt that “feeling fearful takes her off the best track in regard to prioritizing her duties and time management” in her new role. She stated that fear made it hard to know what was priority one, or priority two, or priority three. Ruby said feeling fearful produced anxiety in her personal life and at work. It made it difficult for her to communicate, especially in the work setting. Ruby wanted to be more experienced so she could feel less fearful and have less anxiety. She planned to take more notes as she worked. Ruby said she will “play off of what worked well before and judge for how to go on to the next thing”. She used trial and error to apply what she learned in the past, in new situations. She hoped that her success in her previous jobs would follow into her new role as a CH Nurse. Ruby hopes to be happy at work, at home, in her personal relationships, and have spiritual well being. She wants “a sense of comfort”. For Ruby, gaining more work experience

was the key to reducing her fear and anxiety. She hopes to have less anxiety and increased happiness in all areas of her life.

Ruby's synthesized statements are written according to each objective in her own language:

Objective one is *Meaning*: To describe the significance of feeling fearful.

Feeling fearful is having anxiety and confusion. It is overwhelming.

Objective two is *Rhythmicity*: To describe patterns of relating connected to feeling fearful.

Feeling fearful is not being able to prioritize. It is using trial and error to apply past learning in a new situation. It is taking more notes. Feeling fearful makes it difficult to communicate and difficult to manage time. Feeling fearful is being thrown off track.

Objective three is *Cotranscendence*: To describe concerns, plans, hopes, and dreams related to feeling fearful.

Feeling fearful is wanting more experience in public health in order to decrease fear. It is hoping for success in a new job. Feeling fearful is wanting a sense of comfort and increased happiness in all areas of life.

Pearl's Description of Feeling Fearful

Pearl has been a nurse for 5 years and 8 months. She began working in Community Health 1 year and 8 months ago. She says that feeling fearful is terrifying. For Pearl, “fear is not knowing what I’m suppose to do”. There were so many programs to learn and functions to fulfill as community health care nurse. Transitioning from private sector [nursing] was an adjustment for her. Pearl says, “this was scary”. She says “she is starting to feel more comfortable now”. In the beginning of Pearl’s nursing career, she didn’t have a good routine. As she became experienced as a nurse, her routine improved. Now that Pearl is a CH nurse, she said, “CH nursing throws me off my routine”. She says that feeling fearful still throws her off even now, but not as much as before. Even though Pearl has 5 years experience in nursing and over 1 year in CH nursing, fear still threw her off her routine. Pearl was fearful at work and was not her usual self. She felt consumed by fear at work and outside of work. This fear disturbed “the flow”. She says her office mate could tell when “something was wrong” with her (Pearl). Fear affected Pearl so much that she would not want to discuss it with her supervisor. Her supervisor had an open-door policy, yet this fear would “take over” causing Pearl to shut down and not communicate these feelings. She knew she would have to talk things through with someone. Pearl was nervous about talking to her superior or anyone about her feelings. Pearl planned to ask for help more often. She knows that she will still be thrown off her routine at times. She says, “I have been improving and going to my supervisor”. Pearl is seeking help

when she is struggling with a problem instead of hiding and keep it to herself.

Pearl's hopes and dream is that the fear is replaced with hesitancy. She hopes that fear will not cause her to "not do" something she is suppose to do. Pearl says.

"my hopes and dreams would one day be that, it wouldn't necessarily be fear".

Pearl feels that hesitancy would allow her to think before she acts, but not keep her from doing what needs to be done for her patient. She said, "it might be like hesitancy as far as questioning myself but not like in a fearful enough sense where I really doubted myself and then not do something". Pearl was more fearful in the past. She said, "I went through an extreme period of fearfulness in my first job, but I did still have...fearfulness here because it was a completely different role".

Pearl's synthesized statements are written according to each objective in her own language:

Objective one is *Meaning*: To describe the significance of feeling fearful.

Feeling fearful is terrifying. It is scary and surfaces feelings of nervousness.

Feeling fearful is not knowing what to do; it is disturbing.

Objective two is *Rhythmicity*: To describe patterns of relating connected to feeling fearful.

Feeling fearful is being thrown off [my] routine. Feeling fearful is shutting down and not communicating feelings; but knowing communicating feelings is important. It is seeking help more often when struggling with a problem.

Objective three is *Cotranscendence*: To describe concerns, plans, hopes, and dreams related to feeling fearful.

Feeling fearful is worrying something will not be done that should be done for a patient. Feeling fearful is hoping fear is replaced with hesitancy; hesitancy would allow thinking before acting. Feeling fearful is focusing on improving at work.

Jade's Description of Feeling Fearful

Jade is a nurse of 5 years. She began her role as case manager in community health nursing 9 months ago. Jade's fear was constant. She found it difficult to put her feelings into words regarding fear. She said, "I don't know how to explain it, it was a different kind of fear". Jade was fearful of not succeeding in her new role and was stress[ed] in some ways. She expressed, "fear of not succeeding in my role, but not like my patients weren't [were] gonna die". She describes fear as "a different kind of stress, a different kind of fear, a pleasant kind a fear compared to other experiences". Jade was more diligent in her new role. She wanted to do a good job in her new position. She says, she "arrived early to work so she could take her time, get things done, and be prepared".

Jade was extremely stressed out. This made her "a bit mean". Not only did this affect her personal life but her work relationships also. As Jade learned more skills, she tried to leave stress at work, but at times she was still stressed which came out in her personality as being mean. As time progressed, Jade became more comfortable with herself and her role in CH. Learning more skills helped Jade become less fearful. Jade felt supported by a good staff at work. Jade said, "I feel like I'm supported and I have a good staff around me ". Jade feels that whatever issue she has, she will be alright with the help of her staff.

Jade said even if she fails, “she know she won’t be perfect 100% of the time”, a good staff will get her through. Jade’s staff is so helpful, she feels she can do even more. Jade says, “fear is a part of every role, but hopes to deal with it (fear) appropriately”. Jade hopes that no one suffers because of her fear. She feels it is ok to feel fearful, but patient safety should not be at risk. She says, “I’m fine being fearful, but I want to get my job done”. She wants to be confident even though she is fearful. She hopes her fear will decrease but feels it won’t. Jade says, “I want to be able to deal with it [fear]. Jade says, “good quality, good quantity of fear” will provide self confidence for her. Fear is always with us. Jade stated, “something always comes from fear”. She learns from fear and views it as a “part of life”. Jade notes that CH is different from bedside nursing, but it [CH] is very rewarding and she does not want to leave [CH] because she did something wrong.

Jade’s synthesized statements are written according to each objective in her own language:

Objective one is *Meaning*: To describe the significance of feeling fearful.

Feeling fearful is a constant, unexplainable stressor. It is being fearful of not succeeding.

Objective two is *Rhythmicity*: To describe patterns of relating connected to feeling fearful.

Feeling fearful is being mean in relationships, but working with a good supportive staff that are helpful. Feeling fearful involves difficulty expressing feelings affecting both personal and work life. It is arriving early to work to be prepared. Objective 3: To describe concerns, plans, hopes, and dreams related to feeling fearful.

Feeling fearful is wanting to be more confident in dealing with fear. It is feeling like more can be done and hoping no one suffers. It is wanting to get the job done. It is learning more skills and being diligent in a new role.

Opal's Description of Feeling Fearful

Opal said that fear is [uncomfortable]. As a PH nurse of 9 months, Opal felt a little fearful in her new role. She said, "it's stepping out of your element of what, you know. Opal had been a nurse for 2 and one half years. She reported, "I was use to working in a nursing home or in a hospital, it was a little fearful to be working with people in the community and especially if I were starting to do home visits so I was a little fearful to go into their homes by myself". She said this (PH) is different from "mainstream nursing and nursing school". Opal said, "I went into it trying to be positive and as far as my routine went". She consulted with more people at this job than her other jobs. Opal said, "like I would go to the other nurses more than I did". At the nursing home, she knew what to do. She said, "I don't want to say I was a 'know it all' but I felt like I knew more". Opal was confident and said, "I felt like I knew what I was doing, I did not have to consult with people". Opal feels like she consults with other nurses a lot. Opal

said, “in certain situations especially if I am at a home, you’re the only nurse”. Opal felt alone when it was just her out there, she had to make phone calls and make decisions on her own. Opal felt most of her routine was consulting a lot more. Opal stated, “I definitely consulted a lot more with more experienced nurses there and I definitely go to my supervisor a lot more so than I have at my other jobs”. Opal tried to be positive regarding her routine at work. Opal said her personal relationships were not affected as much. She had good relationships with fiancé’ and parents. Her family was concerned for her safety. Opal’s mother was happy when she got the job, but was nervous for her. Opal said, “her Mom would pray for her when she went on [home] visits”. She could tell that her Dad was worried. He would tell Opal, “a self-defense course” might not be a bad idea. She would tell her fiancé stories and he would be nervous and say, “you shouldn’t be by yourself”. Opal’s relationship with her patients was another story. Opal was fearful when a patient with explosive disorder got angry.

Opal recalls, “I was in his home and he became angry, and so at that point I think it affects the relationship you have with them [patient]”. Opal felt as this point she was no longer the nurse. She said. “in my mind as I’m asking questions “what do I need to say to make him feel better”. Opal was afraid the patient would “blow up on her while at the home. Opal forgot about her nursing role and when into counselor mode. She said, “I was trying to be more of a counselor to him than a nurse at that point”. Opal felt more like a counselor than a nurse during this experience. She said, “[I] was more concerned for safety than the patient

assessment”. Opal said, “I was timid when asking patients personal questions”. It took a few months for Opal to get more comfortable asking her patients personal questions now. Opal plans to continue to consult other nurses for help. She said, “her team has decided to accompany each other on visits when necessary”. Opal does not feel as fearful when she knows the staff are “in this together”. Opal said, “CH has changed so much that even the experienced nurses are fearful”. She said the population is diverse. Opal said she hopes to feel more comfortable going forward. After nine months, she has learned from each situation and is more confident now. Opal wants to be more confident with home visits. She found her new job rewarding.

Opal’s synthesized statements are written according to each objective in her own language:

Objective one is *Meaning*: To describe the significance of feeling fearful.

Feeling fearful is feeling uncomfortable and alone. Feeling fearful is being concerned and worrying about safety.

Objective two is *Rhythmicity*: To describe patterns of relating connected to feeling fearful.

Feeling fearful is going on home visits alone and trying to be positive, but feeling timid on first visits. It is developing a routine of consulting others, nurses, and a supervisor. It is having a good relationship with parents and fiancé`. It is having others pray for safe visits.

Objective three is *Cotranscendence*: To describe concerns, plans, hopes, and dreams related to feeling fearful.

Feeling fearful is planning to continue to consult with other nurses. Feeling fearful is hoping to feel more comfortable going forward and feeling more confident with home visits. It is planning to make team home visits when necessary. Feeling fearful is being involved in a rewarding job.

Emerald's Description of Feeling Fearful

Emerald is a 2 year nurse with 11 months of experience in Public Health nursing. Emerald said that feeling fearful is more like anxiety than it is fear. Emerald said, "It was more anxiety provoking than fearful. She said, "I [it] just may be the nature of my personality, I don't tend to be fearful person, but of course any new situation can create some stress". Even though Emerald is not a fearful person, she said, "new situations create extreme stress" for her. Emerald said, "fear causes her to pause and double check herself more often". She would second-guess herself in new situations. Emerald also said, "double checking a lot of things, more so than I feel like I do now just to make sure, I was doing the right thing, in the correct way". She said, "it was more time consuming". Emerald did not want to make mistakes, she wanted to get things right. Emerald said, "I guess that's really what I'm referring to; it's really more of an increased stressful situation versus being fearful or afraid. Emerald felt that fear strengthens her relationships with people in a positive way. She said, "I would reach out to others to verify things". This helped Emerald get closer to her coworkers. Emerald did not

verbalize specific concerns and plans. When asked about concerns and plans regarding feeling fearful, she said, “I don’t think I do really, I really don’t think I do”. Yet it was important to Emerald to do a good job, not make mistakes if she could help it. Emerald was also concerned about making the right decisions. Emerald said, “She felt she had to learn a lot”. She wanted to learn all she could in her new position. She realized that some challenges were not as big as she imagined before [this job]. Her past life experiences gave her a different perspective that changed her approach to stressful situations. Regarding Emeralds’ hopes and dreams, Emerald said, “well I think some of those [dreams] are already being had realized”. She said, “I’m thinking there is such a big learning curve in the beginning”. As Emerald thinks about going forward, challenges won’t seem so big like before. She noted, “so you realize that what you might think are real challenges in the beginning are the hills aren’t as big as you thought they were”. Emerald has a better view of what is to come. She said,” so it helps to put things in better perspective now.

Emerald’s synthesized statements are written according to each objective in her own language:

Objective one is *Meaning*: To describe the significance of feeling fearful.

Feeling fearful is extremely stressful and anxiety provoking.

Objective two is *Rhythmicity*: To describe patterns of relating connected to feeling fearful.

Feeling fearful is double-checking to get things right. It is reaching out to others to verify things. Feeling fearful strengthens relationships; getting closer to coworkers.

Objective three is *Cotranscendence*: To describe concerns, plans, hopes, and dreams related to feeling fearful.

Feeling fearful is being concerned about making mistakes. It is wanting to learn more. Feeling fearful is having a new and better perspective on stressful situations.

Jasper's Description of Feeling Fearful

Jasper has been an acute care nurse for 24 years, but became a School Nurse 2 month ago. She feared the unknown. She shared, "I think just like fear of the unknown, and what I am doing right now is subbing so it's kind a awkward in that you could be at a different place everyday". Her assignments vary each week and sometimes you only have a manual to guide you. "I was there 6 weeks so that was helpful and I felt like I knew the kids". Jasper shared, "And the next day is a 4 day assignment so I won't get to know those kids at all...you go in blindly and you don't know what to expect. There may be a manual there and um that's it". Jasper said her routine was not affected because you don't know until you go in. You just have to overcome the fear. She said, knowing the routine and getting to know the students" is important. She said, "It's getting to know people, when you first get to the school". It was hard to know the teachers because there was limited interaction with them. "They [teachers] know who you are ...but the teachers, its

kind of a more difficult thing because you don't have as much interaction with them other than on the phone...you can't really put a face with the names".

Jaspers biggest concern was being bored. She disliked not having enough to do".

My biggest concern is being bored". Jasper laughs but relays how much she dislikes "not having enough to do". She said, "I constantly tell my boss, 'please send me to a busy place... I don't want to be bored.' Jasper hopes to have "enough work to fill her day". Jasper is ready to have a school of her own. "It's not like it's my school and I can get x, y, z, paperwork done". She feels like it's not really my responsibility". Jasper hopes to "have a full-time school of my own which I plan to interview for shortly". This gives Jasper a sense of responsibility and belonging. Jasper likes being autonomous. She is confident in her nursing experience of 24 years and enjoys working on her own. She shared, "its definitely different from acute care, I did acute care for so long, but I do feel like community nursing is more autonomous and you really get to utilize your nursing judgment". She reviews the nursing practice act and would like to "implement things" to improve nursing. In CH, "it is different, not like being in acute care where you have to call a doctor"...you really don't have anyone to call, no one to fall back on. Its all you, which I think is great".

Jasper's synthesized statements are written according to objectives in her own language.

Objective one is *Meaning*: To describe the significance of feeling fearful.

Feeling fearful is feeling awkward and alone. It is not knowing what to expect and having to blindly deal with the unknown.

Objective two is *Rhythmicity*: To describe patterns of relating connected to feeling fearful.

Feeling fearful is having students and teachers be strangers; having little interaction with others. It is trying to get to know people and routines in each school.

Objective three is *Cotranscendence*: To describe concerns, plans, hopes, and dreams related to feeling fearful.

Feeling fearful is being concerned about being bored. Feeling fearful is applying for a full-time school giving a sense of responsibility and belonging. Feeling fearful is being confident and enjoying working autonomously. Feeling fearful is wanting to improve CH nursing.

Topaz's Description of Feeling Fearful

Feeling fearful for Topaz was fear of the unknown. She has been a nurse for 33 years and has worked in Community Health for 2 years. She recalled, "I never worked as a certified nurse, I've always worked in a hospital or nursing home".

Topaz had been a nurse for a long time but was ready for a career change. She said, "I was excited about it, because I didn't have to go with sick people". Topaz did not know how the staff would react toward her. Topaz did not anticipate the administrative duties she would have. She commented, "there is a lot of paperwork". She looked forward to "working with healthy people that you are going to come in contact with". Topaz felt, "it was more manageable". Topaz learned new skills but did not like be seen as a new nurse by her peers. "It was a

new skill to me so, I wasn't willing to let them know I was a nurse for 33 years". Topaz confessed, "I was holding back". The new position did not affect Topaz personal relationships as much as her professional relationships. She said, "I was resistant because I didn't know how my peers would accept me, because all members have been here for a very long time, some had been working for 20, 15, 25 years so I held back". Topaz could have worked faster in her routine at work, but she chose not to. She worked "slowly and gradually". Topaz had numerous hopes and dreams for new career. Topaz wanted to impact her patients in the community. She wanted to make a difference in their lives. Topaz hoped to improve health care in the United States. She wanted to empower the community and encourage them to take action for their health. "I wanted to make an impact with the people that I come in contact with". Topaz said, I want to "make a difference in their lives". Topaz wanted to see "changes in disease management, to do like a disease prevention, and empower the people in the community". She wanted to see her community "to take action about their own health and do health prevention [against] smoking, [and] change attitudes". She was concerned about "young ones active and [not] practicing safe sex". She wanted to educate youth about sexually transmitted diseases and provide "eye opening" [insight about] syphilis, gonorrhea". She "dream[s] to remove the stigma to get medication and empower them to set the example that you don't have to follow the group all their lives". Topaz hopes to empower young people to be leaders and not follow the crowd. Topaz concerns lead her to enter CH nursing. "Oh yes, I mean this is why

I entered the hospital [at first], the youth here don't even have adult supervision or they don't have good role models and [are in] drugs and gang members". Topaz admitted, " I am actually afraid for what kind of adult they will grow to be".

Topaz hopes to education teens about sex education and prevention of teen pregnancy. "We have a lot of teenage pregnancy and to empower them about safe sex and...study hard, get a career for themselves, and wait until the proper age for them to marry". They have a lot of tuberculosis around this place". It is important to "educate people around about TB, diseases that are curable and you don't have to be stigmatized". Topaz hopes to "broaden education in the community", letting them know "its much better to use prevention than to do disease management".

She said, "The cost of health care keeps going up and up and up".

Topaz's synthesized statements are written according to each objective in her own language

Objective 1: *Meaning*. To describe patterns of relating connected to feeling fearful.

Feeling fearful is worrying about not knowing what is expected. It also is excitement about a new career.

Objective 2: *Rhythmicity*: To describe patterns of relating connected to feeling fearful.

Feeling fearful is holding back from staff and being resistant. It is seeing if staff will be accepting before opening up. Feeling fearful is learning new skills and working slowly and gradually.

Objective 3: *Cotranscendence*: To describe concerns, plans, hopes, and dreams related to feeling fearful.

Feeling fearful is wanting to make a difference in patients' lives. It is hoping to improve healthcare in the United States; it is being particularly concerned about the health of teenagers. Feeling fearful is wanting to do health education to prevent disease and develop broader health education in the community.

Amethyst's Description of Feeling Fearful

Amethyst has been a nurse for 20 years. She began her career as a School Nurse 1 year and 8 months ago. She was fearful of not knowing what to do and being on her own. In her own words she said, "I guess I'm fearful of not doing everything that was necessary or fearful of not doing things correctly because its a very independent role". Working alone concerned Amethyst, even with 20 years of nursing experience. As Amethyst began this new career, she spent a lot of time learning about the job. She says, "I asked a lot of questions of my coworkers and I read a lot of resources that are provided by the school. Amethyst also, "talked to other nurses who worked in the schools that I work with"...they provided "support and advice". She felt feeling fearful affected her self-confidence. Fear affected "decision-making more than normal" causing her to ask more questions and to doubt her ability. Amethyst planned to learn more and grow as a professional nurse. Amethyst said she planned to "every single day, learn more and grow as a professional in order to be able to provide the best care I possibly can to the children and families" that we care for. Amethyst's hoped to "make a difference in the lives of the children and families of her school. She also wants to "make a difference"...that will cause the "families and children participating in

our programs will have successes in the future”. Amethyst wants her families to benefit because of the “advantages in our program”.

Amethyst’s synthesized statements are written according to each objective in her own language.

Objective one is *Meaning*: To describe the significance of feeling fearful

Feeling fearful is not knowing what to do and feeling doubtful. It is being fearful of not doing everything that is necessary.

Objective two is *Rhythmicity*: To describe patterns of relating connected to feeling fearful.

Feeling fearful is working alone. It is asking a lot of questions. Feeling fearful is relying on others for support and advice.

Objective three is *Cotranscendence*: To describe concerns, plans, hopes, and dreams related to feeling fearful.

Feeling fearful is planning to learn and grow as a professional. It is hoping to make a difference in the lives of children and families. It is wanting success for the children and families in the program.

Sapphire’s Description of Feeling Fearful

Sapphire was a nurse of 5 years. She worked in Community Health for 4 months. When she was fearful, she lacked balance. She said, “I felt I needed to get a balance, because of the structure of CH”. She was most fearful when there was no structure. It was different when I worked at the hospital. As “appose to when you compare to [the] hospital ...”where everything is pretty much standardized ...

but again, that's public health... where you pretty much are all over the place. Sapphire was "anxious and slower" in her routine. She lacked "productivity which made her feel slower "in her routine. Sapphire appeared inexperienced to her peers. She did not want to be perceived as inexperienced to her peers even though she was new to CH. "With peers, you don't want to seem inexperienced"... "even though you are not experienced in Public Health". Sapphire wondered, "how do I strike the balance of not coming off as immature to nurses, even though I am experienced in nursing"... but I'm immature in Public Health". It was difficult for her to know what she was doing in this new routine. "So it affects the work-relationship because you can be perceived as inexperienced. Sapphire also was felt that "lack of resources... manpower... it's huge". This was unexpected in her routine and made the job difficult to manage. When "your by yourself, you find yourself just, doing more than you thought"... "there is not enough people" you get into it and its not enough people, not enough staff". The job was different from what she expected.

"Sapphire plans to go up the chain. She hopes to stay in public health "no matter what". Sapphire was concerned about "going up the chain". She plans to stay "in public health no matter what".

Sapphire's synthesized statements are written according to each objective in her own words.

Objective one is *Meaning*: To describe the significance of feeling fearful.

Feeling fearful is feeling anxious and unbalanced. It is feeling slower in a routine with lack of experience and loss of productivity. Feeling fearful is having difficulty in knowing what to do.

Objective two is *Rhythmicity*: To describe patterns of relating connected to feeling fearful.

Feeling fearful is appearing inexperienced to peers affecting work relationships. It is experiencing lack of resources and lack of structure making the job difficult to manage.

Objective three is *Cotranscendence*: To describe concerns, plans, hopes, and dreams related to feeling fearful.

Feeling fearful is hoping to move up the employment ladder and stay in public health nursing.

Diamond's Description of Feeling Fearful

Diamond worked in Public Health nursing for 2 months and has been a nurse for 2 years and 3 months. She feels that public health nursing is “individually based”. She felt fearful when a school called during her first week at work and reported an outbreak.

During the interview she recalled, “when I first started that week some school called and reported an outbreak. So I was ... a bit fearful of that because I just started [the job] and there was no training”. Diamond stated the previous nurse retired and one other nurse was hired at the time she was. She was alone on this particular day. “I was the only one there”. Diamond was fearful to get such a

phone call so early in her new job, “the school nurse just called”... to report 30 kids out with this stomach virus”. She was fearful of doing the protocols incorrectly. She noted, “because there is a sense of responsibility in reporting correctly...I contacted the nurse manager of PH and she directed me”. She was grateful for good resources. Yet, “it’s a government job, so it’s more like the protocols than the job that’s a little bit scarier”.

Diamond is also fearful “especially when the news... the yellow fever plague and like the norovirus...when all this stuff that’s happening its kind of scary”.

Diamond checked lots of resources during her routine. She says she was a bit “high-strung” during the day”. ... “I definitely check lots of resources, not only people in my department but my county”. She has “to be careful because it’s not like the hospital where there’s many people there...you really have to dig deep a little sometimes, that how it affects my routine...”I really have to like scurry around and look for what ever information I can”.

“And I think because its really broad...Public Health...in terms of affecting my routine, me and my coworker divvy up what needs to be done first”.

Diamond recalls, “So right now we just finished up our immunization audit...and now we’re gonna start training for our CDRSS (Communicable Disease Reporting and Surveillance System) the disease, communicable disease tracking because we don’t want get too mixed up with so many different things”.

Diamond is concerned about doing a new skill. “We just started and we don’t not really sure how it was done before. “Diamond has “strong relationships with her

peers, especially the other new nurse. "...we've never been PH nurses before, we divide work and prioritize work as they learn what to do next". Diamond said, "feeling fearful is awkward". Because everyone else at work is experienced, and we (me and the other new nurse) are so new; it was awkward at times. "We really have to relay on each other...and even in our health department, but its only a few of us...you can feel a bit attention especially when you know we're new and the other people have been there longer". Diamond is concerned that there are so many things she does not know. She plans to keep knowledgeable about her new position. Diamond plans to reach out to the community. I guess just to always ask questions, there's so many things that I don't know"...I try to look up a bunch [of] learning networks...conferences and seminars you can do online. So I try to keep up with those just so I'm ...more knowledgeable about what's going on presently or currently". Diamond plans to "try to be a little more organized". Diamond stated that fear does not go away but she hopes to control it [fear] better one day. She hopes to gain more experience so she can have less fear. "I really don't think you know me dreaming about me being perfect at this job like that's never gonna happen...so I think just really going along with it [fear] of course being attentive to what I do".

Diamond's synthesized statements are written according to each objective in her own language

Objective one is *Meaning*: To describe the significance of feeling fearful.

Feeling fearful is not knowing what to do. It is scary. Feeling fearful is feeling awkward, high-strung and afraid of doing protocols incorrectly.

Objective two is *Rhythmicity*: To describe patterns of relating connected to feeling fearful.

Feeling fearful is contacting the nurse manager for direction. It is checking resources in the department and in the county. It is being concerned about doing a new skill. It is feeling attention from others for being new to the job. Feeling fearful is relying on each other [new people] and building strong relationships.

Objective three is *Cotranscendence*: To describe concerns, plans, hopes, and dreams related to feeling fearful.

Feeling fearful involves planning to reach out to the community and finding resources for learning. It is becoming more knowledgeable. Feeling fearful is hoping to become more organized and gaining more experience so there is less fear.

Themes with Objectives

Themes were developed by “dwelling with participant descriptions” related to each question (Parse, 2001). Interview questions were derived from the 3 objectives. It was helpful to the researcher to compile the participant’s synthesized statements according to each objective to facilitate development of the themes. Themes as noted in the table above, were stated in the participant’s language and in the researcher’s concurring with the objectives.

Participant Language:

Feeling afraid is distressing apprehension arising with not-knowing, with affirming-non-affirming relationships surfacing with work-day engagements, as creative formulating arises with gaining a confident perspective.

Researcher Language:

Feeling afraid is disquieting unease arising with the unforeseen, with unpredictable affiliations surfacing amid diverse encounters, as pondering possibilities arise with potent assuredness.

Objective one is *Meaning* : To describe the significance of feeling fearful

Theme One

Language of Participants: Feeling fearful is distressing apprehension arising with not-knowing.

Language of Researcher: Disquieting unease arising with the unforeseen.

Participants' Synthesized Statements for Objective One

Ruby-Feeling fearful is having anxiety and confusion. It is overwhelming.

Pearl- Feeling fearful is terrifying. It is scary and surfaces feelings of nervousness.

Feeling fearful is not knowing what to do; it is disturbing

Jade- Feeling fearful is a constant, unexplainable stressor. It is being fearful of not succeeding.

Opal-Feeling fearful is feeling uncomfortable and alone. Feeling fearful is being concerned and worrying about safety.

Emerald- Feeling fearful is extremely stressful and anxiety provoking.

Jasper- Feeling fearful is feeling awkward and alone. It is not knowing what to expect and having to blindly deal with the unknown.

Topaz- Feeling fearful is worrying about not knowing what is expected. It also is excitement about a new career.

Amethyst- Feeling fearful is not knowing what to do and feeling doubtful. It is being fearful of not doing everything that is necessary.

Sapphire- Feeling fearful is feeling anxious and unbalanced. It is feeling slower in a routine with lack of experience and loss of productivity. Feeling fearful is having difficulty in knowing what to do.

Diamond- Feeling fearful is not knowing what to do. It is scary. Feeling fearful is feeling awkward, high-strung and afraid of doing protocols incorrectly.

Objective Two – Rhythmicity: To describe patterns of relating connected to feeling fearful.

Theme Two

Language of Participants: Feeling fearful is affirming-non-affirming relationships surfacing with work-day engagements.

Language of Researcher:

Feeling fearful is unpredictable affiliations surfacing amid diverse encounters.

Participants' Synthesized Statements for Objective Two

Ruby- Feeling fearful is not being able to prioritize. It is using trial and error to apply past learning in a new situation. It is taking more notes. Feeling fearful makes it difficult to communicate and difficult to manage time. Feeling fearful is being thrown off track.

Pearl- Feeling fearful is being thrown off a routine. Feeling fearful is shutting down and not communicating feelings; but knowing communicating feelings is important. It is seeking help more often when struggling with a problem.

Jade- Feeling fearful is being mean in relationships, but working with a good supportive staff that are helpful. Feeling fearful involves difficulty expressing feelings affecting both personal and work life. It is arriving early to work to be prepared.

Opal- Feeling fearful is going on home visits alone and trying to be positive, but feeling timid on first visits. It is developing a routine of consulting others, nurses, and a supervisor. It is having a good relationship with parents and fiancé`. It is having others pray for safety.

Emerald- Feeling fearful is double-checking to get things right. It is reaching out to others to verify things. Feeling fearful strengthens relationships; getting closer to coworkers.

Jasper- Feeling fearful is having students and teachers be strangers; having little interaction with others. It is trying to get to know people and routines in each school.

Topaz- Feeling fearful is holding back from staff and being resistant. It is seeing if staff will be accepting before opening up. Feeling fearful is learning new skills and working slowly and gradually.

Amethyst- Feeling fearful is working alone. It is asking a lot of questions. Feeling fearful is relying on others for support and advice.

Sapphire- Feeling fearful is appearing inexperienced to peers affecting work relationships. It is experiencing lack of resources and lack of structure making the job

difficult to manage.

Diamond- Feeling fearful is contacting the nurse manager for direction. It is checking resources in the department and in the county. It is being concerned about doing a new skill. It is feeling attention from others for being new to the job. Feeling fearful is relying on each other [new people] and building strong relationships.

Theme Three

Language of Participants: Feeling fearful is creative formulating arising with gaining a confident perspective.

Language of Researcher: Feeling fearful is pondering possibilities arise with potent assuredness.

Participants' Synthesized Statements for Objective Three

Ruby- Feeling fearful is wanting more experience in public health in order to decrease fear. It is hoping for success in a new job. Feeling fearful is wanting a sense of comfort and increased happiness in all areas of life.

Pearl- Feeling fearful is worry that something will not be done that should be done for a patient. Feeling fearful is hoping fear is replaced with hesitancy; hesitancy would allow thinking before acting. Feeling fearful is focusing on improving at work.

Jade- Feeling fearful is wanting to be more confident in dealing with fear. It is feeling like more can be done and hoping no one suffers. It is wanting to get the job done. It is learning more skills and being diligent in a new role.

Opal- Feeling fearful is planning to continue to consult with other nurses. Feeling fearful is hoping to feel more comfortable going forward and feeling more confident with home

visits. It is planning to make team home visits when necessary. Feeling fearful is being involved in a rewarding job.

Emerald- Feeling fearful is being concerned about making mistakes. It is wanting to learn more. Feeling fearful is having a new and better perspective on stressful situations.

Jasper- Feeling fearful is being concerned about being bored. Feeling fearful is applying for a full-time school giving a sense of responsibility and belonging. Feeling fearful is being confident and enjoying working autonomously. Feeling fearful is wanting to improve Community Health nursing.

Topaz- Feeling fearful is wanting to make a difference in patients' lives. It is hoping to improve healthcare in the United States; it is being particularly concerned about the health of teenagers. Feeling fearful is wanting to do health education to prevent disease and develop broader health education in the community.

Amethyst- Feeling fearful is planning to learn and grow as a professional. It is hoping to make a difference in the lives of children and families. It is wanting success for the children and families in the program.

Sapphire- Feeling fearful is hoping to move up the employment ladder and stay in public health nursing.

Diamond- Feeling fearful involves planning to reach out to the community and finding resources for learning. It is becoming more knowledgeable. Feeling fearful is hoping to become more organized and gaining more experience so there is less fear.

Verification of Findings

Rigor in scholarly writing is accomplished through verification and trustworthy data collection (Rudestam & Newton, 2007, Sieber, 1992; Simon, 2011). Findings were evaluated through credibility, dependability, transferability, and confirmability as mentioned in Chapter 3. Below is further discussion of these processes.

Credibility

Member checking, and triangulation was established to verify trustworthiness in this study. Participants chose the type of member checking option each preferred (Carlson, 2010). All participants reviewed their entire audio taped recording and my notes were dictated to each participant. A copy of my notes was emailed to one participant per request. All participants requested access to the completed dissertation. A link will be emailed to each participant when available. Participants did not request to read their full transcripts. Each audio taped recording was transcribed verbatim by this researcher and 2 IRB approved transcriptionists. Triangulation was also used to assess this study through verbatim transcripts, researcher's notes, and audio taped interviews. Each perspective was evaluated to corroborate the findings of this study (Simon, 2011; Creswell, 2013).

Dependability

Reflexivity was employed through reflexive writing in a personal research journal (Lincoln & Guba, 1985). An expert in humanbecoming served as a reviewer of the data analysis process. The reviewer was not associated with the study. Final themes and

outcomes for this study was evaluated by the expert. The audit trail also outlined the flow of this research (Lincoln & Guba, 1955, Parse, 2011).

Transferability

Transferability was established through documentation of participant demographics and thick description of their experiences of feeling fearful (Hannes, 2011). The target population is described in the inclusion process and through the participant's thick descriptions. Confidentiality was maintained throughout this study.

Participant quotes were used in the data analysis process and saturation of data was achieved revealing no new data (Jansick, 2011; Morse, 1994; Denzin & Lincoln, 1994; Lincoln & Guba, 1985).

Confirmability

Confirmability was addressed through reflexivity and researcher self-evaluation. A research journal was kept throughout this study to record thoughts, beliefs, and values of the researcher. This process of clarification noted any feelings that could color research findings (Creswell, 2007). The author's background was noted in Chapter 3 (Hannes, 2011).

Summary

In summary, this study explored the meaning of feeling fearful for new C/PH nurses. I interviewed 10 new C/PH nurses in the field. Data from each participant transcript was analyzed through coding and analysis-synthesis yielding themes. Themes were developed and elevated through levels of abstraction to yielded findings that answer the question: What is the meaning of feeling fearful? The findings were: Feeling fearful is

disquieting unease arising with the unforeseen, with unpredictable affiliations surfacing amid diverse encounters, as pondering possibilities arise with potent assuredness.

Chapter 5 will discuss interpretations of findings in light of the humanbecoming framework. Limitations, recommendations, and implications will be examined followed by concluding thoughts.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this qualitative descriptive study, I used an exploratory approach to investigate the meaning of feeling fearful for nurses new to C/PH. This method facilitates discovery of patterns and themes about life events retrieved through participant interviews (Parse, 2001, 2014). Chapter 4 notes the findings of this study and the data analysis was explained. This study attempted to: (a) explicate the meaning of feeling fearful, (b) contribute to the understanding of the experience of feeling fearful for new nurses entering C/PH, and (c) contribute to an extant body of knowledge using the humanbecoming school of thought, thus filling a gap in the literature. The humanbecoming school of thought uses three objectives to facilitate the nursing perspective for this study through which the research questions will flow (Parse, 1981, 2001, 2014). The key findings for this study were: *Feeling fearful is disquieting unease arising with the unforeseen, with unpredictable affiliations surfacing amid diverse encounters, as pondering possibilities arise with potent assuredness.*

Themes that were discovered in this study were discussed and supported by participant's quotes and descriptions of feeling fearful. The humanbecoming theory and participant's language will be discussed further as they relate to supporting literature. This chapter will also documents interpretations of these findings, limitations, recommendations, implications, and conclusions.

Interpretation of Findings and Humanbecoming

Theme One and Structuring Meaning

The first research objective was to describe the meaning of feeling fearful. Theme one was: *disquieting unease arising with the unforeseen*, which surfaced in interviews with all participants as they described feeling fearful. Each participant discussed aspects of fear as they reflected about entering C/PH nursing for the first time. The following excerpts by Pearl, Opal, Jasper, and Diamond are presented to further illustrate this theme.

Excerpts from Pearl's interview.

Feeling fearful is terrifying. The fear is not knowing what I'm suppose to do; especially with all the different programs and functions of the community health care nurse. It's a little bit different than private sector, so I did have to adjust to that. It [fear] was a little scary, but I'm starting to feel more comfortable now.

Excerpts from Opal's Interview.

[Fear is uncomfortable]... I felt a little fearful when stepping out of [my] element...it was a little fearful to be working with people in the community and especially if I was starting to do home visits...I was a little fearful to go into their homes by myself.

Excerpts from Jasper's Interview.

I fear the unknown...it's awkward to be at a different place everyday, [not] knowing the routine [or] the students. [With my] 4 day assignment, I won't get to know those kids at all. You...go in blindly and you don't know what to expect.

Excerpts from Diamond's interview.

I was a bit fearful... because I literally just started [public health] and there was no training because the previous public health nurse had already left...I was the only one there. So...I have good resources thank goodness because, you know I was able to contact the nurse manager of public health and she directed me to call the state department. Because it's a government job, the protocols [are] a little bit scarier [than the job]. The school nurse just called and ...I didn't know how I'm to report this [outbreak] 30 kids were out with this stomach virus.

Theme one, *disquieting unease arising with the unforeseen*, can be further explained in connection with the first principle of the humanbecoming theory, which is "Structuring meaning is the imaging and valuing of languaging", (Parse, 2014, p. 35). Meaning arises with humanuniverse and "refers to the significant moments of everyday living; it changes with new experiences that shift values, shedding a different light with the becoming visible-invisible becoming of the emerging now" (Parse, 2014, p. 33).

This principle is further clarified as three concepts, imaging, valuing, and languaging, which are defined separately. The first concept, imaging, "is reflective-prereflective coming to know the explicit-tacit all at once" (Parse, 2014, p. 38).

Disquieting unease arising with the unforeseen involved distressing apprehension with not knowing what to do or being faced with the unknown.

Participants in my study struggled with knowing and not knowing what to do in their new roles and in certain situations. Pearl stated, “Fear is not knowing what I’m suppose to do.” For Topaz, “It is fear of the unknown.” Pearl and Topaz illustrated explicit knowing as they reflected on their experiences verbally, thus using “utterable” language. [transition is needed here to explain the relationship of tacit knowledge to the previous.] Tacit knowing “is prereflective unutterable knowing” (Parse, 2014, P. 37). This concept was illustrated by a few participants in my study who found it difficult to describe fear in words. For example, Ruby stated, “Fear makes it difficult for me to communicate”. Jade said, “I don’t know how to explain it [fear]”.

“Parse noted that explicit-tacit knowing is living reflectively-prereflectively all at once”, (Parse 1981, 2014, p. 37). Jasper, also stated, “I think...fear of the unknown” described fear as a new C/PH nurse. Amethyst was fearful of not knowing what to do. Ruby, a CH nurse, stated that feeling fearful was marked with anxiety and caused confusion, yet she is not new to nursing. Amethyst was doubtful and stated she was “worried about not doing everything that was necessary” in her CH role.

Valuing is the second concept of structuring meaning; it “is all-at-once confirming-not confirming cherished beliefs in light of a personal worldview” (Parse,2014, p. 39).

Participants valued the fact that there were more experienced nurses available to consult with them, but at the same time were fearful of the new experiences they found threatening to their role as a C/PH nurse. Diamond stated, “I was a bit fearful...I literally just started and there was no training.” During a viral outbreak at a school, she was called

to assist with this potential emergency. Diamond admitted, “I have good resources thank goodness; I was able to contact the nurse manager.” Opal also noted, “I definitely consulted a lot more with ...experienced nurses.” She was “timid” during home visits and “asking personal questions.” Opal is more comfortable now with home visits.

The third concept of structuring meaning signifies valued images with “speaking-being silent, moving-being still” (Parse, 2014, p.37). [Please summarize this quote in your own words to explain what it means.] Language is not just what is said, but includes the entire message. Participants used language and silence to express feeling fear. Ruby expressed moments that made it “difficult for her to communicate.” She felt this was especially true for her at work. Jade said, “I don’t know how to explain it [fear].” At times, Jade could not find words to describe feeling fearful. Another C/PH nurse, Topaz, was silent about her past experience as a nurse. She said she was “holding back.” Topaz wanted to know that her environment was safe before revealing her past experience. She also wanted to know “that her peers accepted her.”

Concepts similar to *disquieting unease arising with the unforeseen* were found in related nursing research. In a study on feeling unsure, Bunkers (2007) discovered the paradox of *disquieting apprehensiveness surfacing with contemplating the known and not-known*, describing how people can feel unsure about a “new job or making important decisions” (2007, p. 56). Bunkers’ concepts were similar to my themes: disquieting unease arising with the unforeseen. Bunkers’ (2007) participants were troubled about not knowing the future concerning life expectancy. *Learning a new culture* is a theme uncovered by Yancey (2005, p. 216) in a study on illuminating the experiences of novice

nurses was described by participants as “not knowing what papers to fill out, and not knowing who to call”.

In a study by Morrow (2010) on feeling unsure, findings were *discomforting trepidation with unassuredness-assuredness*; participants experienced anxiety and doubt all at once. A participant from Morrow’s study indicated feeling uncomfortable and having doubt, yet being confident.

Being respected was also discovered by Yancey (2005), as a participant expressed “frustration when she hears older nurses being negative about patients and treating colleagues disrespectfully.” Another participant in Yancey’s study, Jana was “happy” that nurses at her hospital were treated with respect and she felt listened to by the experienced nurses. The participants in Yancey’s study thus illustrated the confirming-nonconfirming concept (Yancey, 2005). These assertions are congruent with *haunting possibilities with cautious perseverance* and further illustrates my finding of *disquieting unease arising with the unforeseen*. Minimal research was found to specifically address feeling fearful as it related to humanbecoming and C/PH nurses.

Theme Two and Configuring Rhythmical Patterns

The second research objective was to describe the rhythmical patterns of relating connected to feeling fearful, and the theme that surfaced for all participants was *unpredictable affiliations surfacing amid diverse encounters*. This theme surfaced as the participants discussed relationships with family and coworkers, careers goals, and day-to-day routines. Excerpts from interviews with Pearl, Jade, Opal, Diamond illuminate this theme.

Excerpts from Pearl's Interview

Fear throws me off [my routine]. [When] I am fearful at work, I am not my normal self outside of work... I am usually consumed [with fear]. In the work, setting [fear] disturbed the [routine] flow. My office mate... even picked up...that something was wrong. [Fear] makes me nervous to even go to my supervisor...fear sometimes takes over and [I] don't want to talk about it.

Excerpts from Jade's Interview

[Fear makes me] more diligent, I'd... get [to work] earlier so I can take my time and not rush. I was extremely stressed out. I picked up more skills and tried to leave the stress at work. I was a mean person.

Excerpts from Opal's Interview

I went into [public health] trying to be positive. I consulted with the other nurses,[asking] what to do in certain situations especially if I am at a home [visit]. [I'm] the only nurse [on home visits] and I have to make phone calls and decide things on my own. I go to my supervisor a lot more than I have at my other jobs. I feel like [fear] didn't affect my relationships at home. [My family] worried [about] my safety...for example my Dad [said take] a self-defense course...[and] my fiancé was a little nervous and said you shouldn't be by yourself... my Mom...was a little nervous for me and would say a prayer for me whenever I'd go out on my visits. [In] one situation I was a little fearful [because] this patient had explosive disorder and I was in his home when he became angry. I think [fear] affects the relationship you have with [the patient].

[I was] more timid...And even the nurses who have been there for a while are still fearful.

Excerpts from Diamond's Interview

Because of that fear I definitely checked lots of resources [from] people in my department [and] my county. Fear makes me... more high strung.

(laugh), you know just to be careful because it's not like the hospital where there is just so many, there literally so many people there. This is kind of more like, um you really have to kind of dig deep a little sometimes, that how it affects my routine. My [new] coworker and I have a strong relationship because we are so new and we really have to rely on each other. You can feel [the] attention [because] we're new and the other people [nurses] have been there longer so it's awkward.

Theme two, *unpredictable affiliations surfacing amid diverse encounters*, is connected to the second humanbecoming principle of “configuring rhythmical patterns is the revealing-concealing and enabling-limiting of connecting-separating” (Parse, 2014, p. 43). “Configuring is living humanuniverse rhythms with the becoming visible-invisible becoming of the emerging now” (Parse, 2014, p. 44). This principle, like the first, has three concepts that I will discuss in detail.

The first concept of principle two is disclosing-not disclosing of revealing-concealing. “Pattern preferences arise with inherent freedom to choose the impenetrable mystery of humanuniverse” (Parse 2014, p. 43). C/PH nurses illustrated this initial concept by concealing true feelings while revealing other feelings with staff nurses. Pearl

stated that fear affected her relationships at work, even her officemate could “tell something was wrong.” She experienced fear but shared that she did not want to talk with her supervisor about her fear. Another participant, Sapphire, did not share openly with her coworkers. She stated, “with peers, you do not want to seem inexperienced.” Participant’s outer behavior did not match their feelings which were hidden from their peers, thus illustrating unpredictable affiliations which leads to diverse encounters.

The second concept, enabling-limiting is potentiating-restricting (Parse, 2014). “In choosing, the individual moves in one direction, which restricts movement in another, and there are illimitable opportunities and in what is chosen and opportunities and restrictions in what is not chosen” (Parse, 2014, p. 45). For example Sapphire said, “I want to move up the chain, there is not enough resources but I’m not going anywhere. She is more comfortable working in the hospital. Sapphire stated, “I had a better routine; the hospital was more standardized”. Even though C/PH nursing is different and even harder in some ways, she wanted to stay in C/PH.

The third concept, connecting-separating is attending-distancing; “it is living being with and apart from others, ideas, objects, and situation all-at-once” (Parse, 2014, p. 45). In daily living, the individual is “all-at-once close to some phenomena and distant from others” (Parse, 2014, p. 46). Unpredictable affiliations surfacing amid diverse encounters is affirming-non-affirming relationships that occur during the workday. Opal stated, “I was in his (the patient’s) home and he became angry, and so at that point I think it affects the relationship”. Opal no longer “felt like a nurse, but a counselor”. She felt distanced from her patient due to fear, yet she wanted to help her patient. Emerald noted

“that fear strengthened her relationships as she “would reach out to other (nurses) to verify things”. As Emerald became more independent in her role, she said, “she doesn’t want to make mistakes”.

Extant literature that revealed comparable concepts to *unpredictable affiliations surfacing amid diverse encounters* was a study on feeling respected-not respected by Bournes and Milton (2009) which answered the question: *What is the structure of the lived experience of feeling respected-not respected?* Findings that emerged from Bournes and Milton’s (2009) study were *affirming-not affirming attentiveness, with diverse affiliations arising with assuredness-unassuredness*; illustrating that nurses felt accepted. Similar themes such as *reassuring affiliations* surfaced in Baumann’s study on feeling fear (Baumann, 2009). Also participants in Baumann’s study discussed being “in a specific time and place, and in various relationships with others” (Baumann, 2009, p. 353). One participant worked in the inner city and feared students there, but over time conquered her fears because she had to make a living (Baumann, 2009). Other participants in Baumann’s study noted the significance of facing fears and moving beyond those feelings. Similarly, Opal, a CH nurse in my study, was fearful of asking her patients personal questions during home visits. She was more confident after confronting her fear.

Research literature noted that graduate nurses encounter unexpected situations as they began home visits and struggled as they strive for independence, yet need to rely on each other when a visit was more than they could handle (Sneltvedt et al. 2010). All participants illustrated this principal throughout the day-to-day routines, as their

interactions with others was ever changing, as they were revealing-concealing who they really were. The relationships varied with changing transparency on both sides. Each day was unpredictable as circumstances arose, thus the potentiating-restricting of enabling-limiting affected their learning. “Patterns of relating arise with inherent freedom in the impenetrable mystery of being human (Parse, 2007, p. 309).

Fear is inevitable according to the literature; studies involving new nurses have documented the unnerving experience of working in the hospital for the first time (Kramer, 1974; Duchscher, 2009). Similar themes that have surfaced in earlier nursing studies are anxiety, stress, and lack of support (Kramer, 1974; Duchscher, 2009; Cho, Laschinger, & Wong, 2006; Kramer et al., 2013; and Sneltvedt et al.: 2010). Minimal research was found to address feeling fearful as it relates to routines and relationships of new nurses in C/PH.

Theme Three and Cotranscending with Possibles

Theme three from objective three was *pondering possibilities arise with potent assuredness*. The objective was to describe concerns, plans, hopes, and dreams related to feeling fearful. Participants illustrated this theme as they spoke of aspirations and improving their communities. Excerpts from Pearl, Jade, Opal, Jasper, Diamond illustrate this theme.

Excerpts from Pearl’s Interview

I’m learning [to] ask for help more now... that is my plan. My hopes and dreams one day, is to be hesitant as far as questioning myself and not [be] fearful and doubting myself. I really like community health so I’m not going anywhere.

Excerpts from Jade's Interview

I'm supported and I have a good staff around me...

I can do more knowing that I have that support, even if I fail, but I hope I won't fail. I know that fear is a part of every role, but I just want to make sure I deal with it appropriately and that no one suffers from [my fear]. [Community health nursing] is very rewarding.

Excerpts from Opal's Interview

[I hope] to continue to consult with other nurses. We've become a close team and I know that I can always go to them.

We accompany each other on visits now if we feel it's necessary. I don't feel as fearful because I know that we are all in this together.

Community health has changed...It's not just the little older people that, you know, we are seeing a lot different people now a days. It is a diverse population. My hopes and dreams... [are to] learn more about my program and feel more comfortable...I feel like that's already happening. I've been there for about 9 months now and you know with every situation you learn and you just grow to be more confident. It is very rewarding and I like helping the people in our community that really need it.

Excerpts from Jasper's Interview

My biggest concern is being bored and not having enough to do...

I want to get a fulltime school of my own which I plan to interview for shortly. Community nursing is more autonomous...you get to utilize your nursing judgment.

Excerpts from Diamond's Interview

[I plan to] ask questions [because] there's so many things that I don't know.

[I plan to] look up networks, conferences, and seminars...to attend.

[I plan to be] more knowledgeable about what's going on currently...

[I plan to]be a little more organized and to reach out to the community.

[My plans are] collaborating [with] hospitals in the area, developing good relationships so we can make the community healthier. I don't think that fear is ever really going to go away, but I think it can be ... better controlled once I get more experience...being perfect [will] never happen. I really like seeing the community approach [in nursing].

Theme three, *pondering possibilities arise with potent assuredness*, is related to the third humanbecoming principle which is “cotranscending with possibles is the powering and originating of transforming”. “This principle means that humanuniverse is the grounding for cotranscending with possibles in cocreating a seamless reality illimitably with the paradoxical rhythms” (Parse, 2014, p. 47). The three concepts of the third principle are powering, originating, and transforming. Powering is the pushing-resisting of affirming-not affirming being in light of-nonbeing (Parse, 2014, p. 49). This concept was illustrated as participants spoke of what they hoped for in coming months. For example, Opal hoped to “feel more comfortable going forward”. She wanted to be

more confident during home visits. Topaz wanted to make a difference in her patient's lives. She wanted "to improve healthcare in the United States".

The next concept of principle three is "originating is inventing new ways of conforming-not conforming with the certainty-uncertainty of living (Parse, 2014, p. 50). Participants demonstrated this concept as they functioned in their new setting, emulating their preceptors, yet defining their unique practice individually. Opal was timid when making home visits. She hoped to be more confident in this area. She plans to "consult more with her team", yet "meet her patient's individual needs" as a relationship develops. Opal stated, "her team has decided to accompany each other on visits when necessary". Opal feels good about this change but wants to be able to practice individually as a C/PH nurse.

The final concept of principle three is transforming (Parse, 2014). "Transforming is shifting the view of the familiar-unfamiliar, the changing of change in coconstituting anew in a deliberate way with the unexplainable mystery of human universe" (Parse, 2014, p. 51). C/PH participants wanted to be successful in their new roles. Each nurse yearned for more work experience and success at work, thus illustrating the third principle. Most of the nurses were hopeful as they became more confident in their roles. Jasper was fearful of being bored. She said, she constantly told her boss, "I don't like not having enough to do" and she hoped to "have enough to fill [her] day". Jasper said "I'm ready to have my own school". She wanted to work at a busy school and manage a school of her own.

Another participant, Amethyst's hopes to "make a difference in the live of the children and families of her school". She plans to learn more from her C/PH peers and "grow as a professional. Topaz stated, "I want to make an impact with the people that I come in contact with". Jasper, on-the-other-hand enjoyed autonomy in her position. She stated, "...I do feel like community nursing is more autonomous and you really get to utilize your nursing judgment". Emerald is learning to put things in perspective, she said, "challenges won't seem so big like before...it helps to put things in better perspective".

Yancey (2005) published similar research with 10 new graduate nursing students regarding being a novice nurse. Themes found in this study included: "learning a new culture, sharing a journey, being unsure with changing views, considering the possibles, and being respected". Several themes in Yancey's study were comparable to my themes; pondering possibilities arise with potent assuredness (Yancey, 2005 p. 215). Congruent research by Baumann (2013) noted that feeling bored described the experience as *wearisome dullness surfacing with uplifting engagements*. This study of 10 older people with depression noted such descriptions as a "monotonous routine". Other participants described feeling bored as "the same old routine over and over again" (Baumann, 2013, p. 47). Another study investigating an Associate Degree Nursing (ADN) internship program initiative was conducted in Home Health Service in New York (Rosenfeld, Chaya, Lewis-Holman, & Davin, 2010). The investigators in this Home Health Service study, found similar themes such as support from staff and managers, application of knowledge learned, and patient teaching in the community setting (Rosenfeld et al., 2010). Pondering possibilities arise with potent assuredness was reinforced by the above

similar themes in the extant literature. All participants ended their interviews with optimism and hope as they dreamed of continuing a career in C/PH nursing for the near future. Though the extant literature was limited regarding studies that focused on feeling fearful for new C/PH nurses, similar concepts were discovered.

Limitations

Numerous strategies were implemented to ensure trustworthiness, yet limitations were noted in this study. This qualitative descriptive exploratory study required a targeted sample size, thus limiting diversity of gender and ethnicity. A small participant size served the purpose of this inquiry, but does not represent all C/PH nursing populations (Parse, 2001; Baumann, 2009). Purposeful sampling also limited the transferability of this study to a larger nursing population. Another limitation was nurses with masters' degrees in nursing and associate degrees in nursing were not represented in this study. This research focused on the East Coast covering only a few states surrounding Maryland and Delaware, which limited representation of other C/PH facilities.

Another weakness in this study was time constraints. More data would be available if the participants were interviewed at different phases of their nursing journey. Interviews from new nurses at one year, two years, and five years would provide more information for comparison analysis. This information would be valuable to the workforce of C/PH agencies, educators, and nurse administrators. The participants in this study provided ample data for discovery of new knowledge regarding feeling fearful in the C/PH setting.

Recommendations

This study provides new insight regarding C/PH nurses feeling fearful. The following recommendations provide ideas for further investigation of C/PH nursing. The initial theme for this study was: *disquieting unease arising with the unforeseen*. Studies that could immerse from the first theme are feeling inexperienced, feeling stressed in a new environment and the experience of being new. The next theme was *unpredictable affiliations surfacing amid diverse encounters*. Studies to address this theme could be feeling transparent, feeling accepted, nurse perceptions of new C/PH nurses, feeling appreciated. The third and final theme was *pondering possibilities arise with potent assuredness*. Studies could focus on feeling experienced, a comparison study could evaluate C/PH nurse confidence levels before and after orientation or residency program, a comparative study could be done with new C/PH nurses with various years of RN experience and educational levels. Lastly, a residency program for new C/PH nurses could be developed as a doctoral project using humanbecoming teaching-learning model or the mentoring model.

According to Merriam-Webster, a mentor is “someone who teaches or gives help and advice to a less experienced and often younger person” (Merriam-Webster, 2016). “For humanbecoming, mentoring is a moment-to-moment unfolding of scholarly togetherness-aloneness in the indivisible, unpredictable, ever changing pattern of coming to know the new with the becoming visible-invisible of the emerging now “ (Parse, 2012; 2014, p. 140).

This model differs from traditional mentoring, thus emphasizes “incarnating meaning, unfolding pattern, and shapeshifting possibilities arising with committing with enthusiasm, diligent loving presence, and venturing with the new” (Parse, 2014, p. 142). The humanbecoming mentoring model “specifies assumptions, essences, and processes” that illustrate ways of being together in mentoring relationships” (Parse, 2014, p. 140). For example, the mentor and the protégé participate in a relationship that is mutual.

Time spent together also includes knowings that may show pushing-resisting since each individual does not know everything about the other; and what is visible or hidden [explicit-tacit] (Parse, 2014). As they move forward in this relationship, pattern preferences immerge that live on for years to come. “Mentoring is a cocreated reality surfacing in the becoming visible-invisible becoming of the emerging now with mentor and protégé” (Parse, 2014, p.140). Examples of living the three humanbecoming mentoring processes with new C/PH nurses are as follows:

Impelling gentle urging is a way of being present to the protégé without judging what they are feeling, especially if they are feeling afraid. The mentor encourages the new nurse to be clear about what she or he needs for support when going into a new practice situation.

Attentive respecting is providing guidance with respect. The mentor may ask the new nurse how the mentor can be supportive when the new nurse is faced with a fearful situation.

Prudently endeavoring is sharing insights into what choices are working for the new nurse and what might the new nurse do differently when dealing with the

uncertainty of new situations. For example, a C/PH nurse attending a new school would share how this experience was fearful and would reflect and write about dealing with such feelings and lessons learned. Thus, this mentoring model would benefit new and experienced nurses entering C/PH or any new position.

Further, this study will be useful to healthcare administrators, community stakeholders, nursing students, nurse graduates, experienced nurses, nurse educators, and public health officials in regard to promoting healthier workforces and communities. The literature continues to support the need for additional research in C/PH and a deeper understanding of the new nurse experience in this setting. Kramer and Duchscher (1974, 2009) provided a foundation of research with graduate nurses and this work should be continued to improve the health of our communities and develop a stronger C/PH workforce.

Implications

The implications for social change are multifaceted. Theoretically, this study extends the scientific base of nursing by illuminating the understanding of meaning, affiliations, ideas, and possibilities that connect to the lived experience of feeling fearful. This study therefore, produces new knowledge and expands the theory of humanbecoming (Parse, 2007).

Findings in this study can potentially guide nursing practice in the C/PH workforce by increasing awareness of the affects of feeling fearful before, during, and after the orientation phase of training. Awareness, then could lead to solutions that

promote learning and facilitate non-threatening settings for nursing students and new nurses who engage C/PH settings for the first time.

Additionally, as society relies more on technology and data, less emphasis is placed on humankind. The humanbecoming perspective shifts the focus to human beings; which positively affects individuals, families, and communities (Parse, 2007). “The assumptions and principles of humanbecoming incarnate a deep concern for the delicate sentiments of being human and show a profound recognition of human freedom and dignity” (Parse, 2007, p. 310). A reoccurring theme among the participants in this study expressed the desire and need to care for their patients and communities with dignity and compassion. Feeling fearful was noted as hindering this process unless one learned positive ways to address these feelings. It was also noted by participants, that a supportive setting was conducive to reducing fearful feelings in the workplace. As the future of C/PH unfolds, nurse executives and educators are shaping outcomes, thus “shaping the discipline. Rilke (1903-1908/1993, p. 65) noted “the future enters into us...long before it happens”. This study provides an awareness of nurses’ perspective of feeling fearful as they entered the workforce of C/PH.

This qualitative study could increase understanding of the phenomenon of feeling fearful, which could lead to improved curriculum in nursing programs, decreased fear in clinical rotations, and improving orientation programs across other disciplines as well. Such knowledge would lead to healthier work environments and stable communities (Akhu-Zaheya, Khater, Nasar & Khraisat, 2011). The findings of this study has the potential to facilitate reflections regarding feeling fearful. Nursing faculty and

administrators will be exposed to information that provides understanding of the experiences of feeling fearful.

Fear is experienced as people interact at home, work, and in activities of daily living. Nursing curriculum offers minimal guidance to prepare new nurses to deal with fear as they enter a career in nursing (Bunkers, 2003). The perspective of the new C/PH nurses provides valuable insight to nurse executives, educators, and health care stakeholders that could increase attraction of nurses to their C/PH facilities, and retain new staff.

Additionally, this information has the potential to improve nursing curriculum, nurse residencies, and nursing orientation by illuminating nurses experience of feeling fearful, thus creating a nonthreatening environment for C/PH workforce to thrive,

Conclusions

The purpose of this qualitative descriptive exploratory study was to explore the meaning of feeling fearful. The population was new nurses in C/PH. The primary research question was: What is the meaning of feeling fearful? The data from this study was gathered from interview questions that addressed 3 objectives that answered the research question.

The findings of this study contributed to the understanding of feeling fearful, thus fulfilling a gap in the literature. The significant findings in this study were: *Feeling fearful is disquieting unease arising, with the unforeseen, with unpredictable affiliations surfacing amid diverse encounters, as pondering possibilities arise with potent assuredness.*

Implications for this study could affect social change on various levels as noted previously. The findings of this study are significant to the local practitioner, educational institutions, and public schools. Fear is a universal emotion, thus affecting multiple levels of learning. Through exploration and awareness, nursing executives and community stakeholders can provide educational opportunities to nursing students and new nurses. Non-threatening work environments could be promoted thus providing a healthier workforce. This study focused on feeling fearful, thus data regarding retention and nursing productivity is a limitation as noted earlier and is useful for future studies.

In summary, this study affirms that feeling fearful is an emotion that is experienced in a C/PH population at various levels of nursing practice. Though a small participant sample was selected, the findings express rich data that is significant to humankind and the future health of C/PH nursing and its communities. New information was discovered from this study as we seek to improve the C/PH workforce, and create healthier communities.

References

- Akhu-Zaheya, L. M., Khater, W., Nasar, M., & Khraisat, O. (2011). Baccalaureate nursing students, anxiety related computer literacy; a sample from Jordan. *Journal of Research in Nursing, 18*(1), 36-38. doi: 10.1177/1744987111399522
- American Nurses Association [ANA]. (2010). Nursing: scope and standards of practice. American Nurses Publishing. Retrieved from <http://www.nursesbooks.org/ebooks/download/NursingScopeStandards>
- APHA (2015). What is public health? American Public Health Association. Retrieved from <https://www.apha.org/>
- Arthur, K. (2013). *The New Inductive Study Bible* [English Standard Version]. Chattanooga, TN: Precept Ministries International.
- Ballem, A. & MacIntosh, J. (2014). A narrative exploration: Experienced nurses' stories of work with new graduates. *Western Journal of Nursing Research, 36*(3), 374-387. doi: 10.1177/0193945913502131
- Baumann, S. L. (2009). Feeling fear: A humanbecoming study of older adults. *Nursing Science Quarterly, 22*(4), 346-354. doi: 10:1177/0894318409344751
- Bournes, D. A. Nurses' experiences of feeling respected-not respected. *Nursing Science Quarterly, 22*(1). doi: 10.1177/0894318408327294
- Breakwell, S. (2004). Connecting new nurses and home care. *Home Health Care Management Practice, 16*(2), 117-121. doi: 10.1177/1084822303258219
- Bunkers, S. S. (2003). Facing fear. *Nursing Science Quarterly, 16*(2), 120-125. doi:10.1177/08943251776

- Bunkers, S. S. (2007). The experience of feeling unsure for women at end-of-life. *Nursing Science Quarterly*, 20(1), 56-63. doi: 10.1177/0894318406296294
- Bunkers, S. S. (2016). The living experience of feeling unsure: A Parsesciencing inquiry. *Nursing Science Quarterly*, 29(4), 288-298. doi: 10.1177/0894318416663942.
- Burns, N., & Groves, S. K. (2005). *Practice nursing research: conduct, critique, and utilization* (5th ed.). St. Louis, MO: Elsevier Saunders.
- Carlson, J. (2010). Avoiding Traps in Member Checking. *The Qualitative Report*, 15(5), 1102-1113. Retrieved from <http://www.nova.edu/ssw/QR/QR15-5/carlson.pdf>
- Cho, J., Laschinger, H. K. S., & Wong, C. (2006). Workplace empowerment, work engagement, and organizational commitment of new graduate nurses. *Nursing Leadership*, 19(3), 43-60. Retrieved from http://www.researchgate.net/publication/6755559_Workplace_empowerment_work_engagement_and_organizational_commitment_of_new_graduate_nurses
- Creswell, J. W. (2009). *Research design: qualitative, quantitative, and mixed methods approaches*. (3rd ed.). Thousand Oaks: CA: Sage Publications.
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Corbin, J., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, 13(1), pp. 3-21.
- Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publications.
- Dewey, J. (1910). *How We Think*. New York, NY, D. C. Heath & Co., Publishers

- Dewey, J. (1997). *Democracy and Education*. New York, NY: Free Press.
- Drummond, S. (2012). Feeling overwhelmed in mothers of children with diabetes: A Parse method study. Dissertation. ProQuest.UMI: 3527390
- Duchscher, J. E. B. (2009). Transition shock: the initial stage of role adaptation for newly graduated registered nurses. *Journal of Advanced Nursing*, 65(5), 1103-1113. doi: 10.1111/j.1365-2648.2008.04898.x
- Eide, P., & Kahn, D. (2008). Ethical issues in the qualitative researcher-participant relationship. *Nursing Ethics*, 15(2), 199-207. doi: 10.1177/0969733007086018.
- English, A., & Stengel, B. (2010). Exploring fear: Rousseau, Dewey, and Freire on fear and learning. *Educational Theory*, 60(5), 521-542. Retrieved from <http://nsq.sagepub.com.ezp.waldenulibrary.org/content/18/3/215.2.full.pdf+html>
- Freire, P. (2005). *Teachers as Cultural Workers: Letter to Those Who Dare Teach*. Boulder, CO: Westview Press.
- Furedi, F. (2007). The only thing we have to fear is the “culture of fear” itself. Essay. Online. Retrieved from <http://frankfuredi.com/pdf/fearessay-20070404.pdf>
- Granger, R. (2010). *The Uses of Chaos*. Bern, Switzerland: Peter Lang AG, International Academic Publishers.
- Hannes, K. (2011). Chapter 4: Critical appraisal of qualitative research. In: Noyes J, Booth A, Hannes, K, Harden A, Harris J, Lewin S, Lockwood C (editors), *Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions*. Version 1 (updated August 2011). Cochrane

- Collaboration Qualitative Methods Group, 2011. Retrieved from <http://cqrmg.cochrane.org/supplemental-handbook-guidance>.
- James, W. (2007). *What is an Emotion?* Radford, VA: Wilder Publications.
- Janesick, V. (2011). *Stretching: Exercises for Qualitative Researchers* (3rd ed). London: Sage.
- Janghorban, R., Roudsari, R.L., & Taghipour, A. (2014). Skype interviewing: The new generation of online synchronous interview in qualitative research. Commentary. *International Journal of Qualitative Studies on Health and Well-being*, 9: 24152 <http://dx.doi.org/10.3402/qhw.v9.2.24152>
- Keane, J. (2001/2011). *Democracy and Fear*. Berlin. Retrieved from http://johnkeane.net/wp-content/uploads/2011/01/fear_and_democracy.pdf#page=2&zoom=auto,-82,679
- Kierkegaard, S. (1843/1983). *Fear and Trembling*. New Jersey: Princeton University Press. Edited and Translated by H. Hong.
- Kulbok, P. A. & Ervin, N. E. (2012). Nursing science and public health: contributions to the discipline of nursing. *Nursing Science Quarterly*, 25(1). doi: 10.1177/0894318411429034
- Kramer, M. (1974). *Reality Shock: Why nurses leave nursing*. St. Louis, MO: C. V. Mosby Company.
- Kramer, M. B., Brewer, B., & Maquire, P. (2013). Impact of healthy work environments on new graduate nurses' environmental reality shock. *Western Journal of Nursing Research*, 35(3), 348-383. doi: 10.1177/0193945911403939

- Lincoln, Y.S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.
Retrieved from <http://books.google.com/books?http://scholar.google.com/scholar>
- Lupton, D. (1999). *Risk*, London: Routledge.
- Ma, L. (2014). A humanbecoming qualitative descriptive study on quality of life with older adults. *Nursing Science Quarterly*, 27(2), 132-141. doi: 10.1177/0894318414522656
- Merriam-Webster Inc. (2015). Dictionary and thesaurus. *Encyclopedia Britannica Company*. Retrieved on <http://www.merriam-webster.com/dictionary/fear>
- Merriam-Webster Inc. (2016). Dictionary and thesaurus. *Encyclopedia Britannica Company*. Retrieved on <http://www.merriam-webster.com/dictionary/mentor>
- Morrow, M. R. (2010). Feeling unsure: A universal lived experience. *Nursing Science Quarterly*, 23(4), doi: 10.1177/089431840380255
- Morse, J. (1994). "Designing funded qualitative research". In NK. Denzin and YS Lincoln (Eds.) *Handbook of Qualitative Research* (220-235). Thousand Oaks, CA: Sage Publications.
- Murray, T. (1993). From outside the walls: A qualitative study of nurses who recently changed from hospital-based practice to home health care nursing. *The Journal of Continuing Education in Nursing*, 29(2), 55-60.
- NVivo 10 (2013). NVivo 10. http://www.qsrinternational.com/products_nvivo-mac_features-and-benefits.aspx
- Pain, R. & Smith, S. J. (2008). *Fear: Critical Geopolitics and Everyday Life*. Burlington, VT: Ashgate Publishing Company

- Parse, R.R. (1981). *Man-living-health: A theory of nursing*. New York: Wiley.
- Parse, R. R., Coyne, A. B., & Smith, M. J. (1985). *Nursing research: Qualitative methods*. Bowie, MD: Brady.
- Parse, R. R. (1996). Building knowledge through qualitative research: A road less traveled. *Nursing Science Quarterly*, 9(1), 10-16. doi: 10.1177/089431849600900105
- Parse, R.R. (1996). Quality of life of persons living with Alzheimer's disease: The humanbecoming perspective. *Nursing Science Quarterly*, 9, 126-33. doi: 10.1177/089431849600900312
- Parse, R. R. (2001). *Qualitative inquiry: The path of sciencing*. Sudbury, MA: Jones and Bartlett Publishers and National League of Nursing.
- Parse, R. R. (2007). The humanbecoming school of thought in 2050. *Nursing Science Quarterly*, 20, 308-311. doi: 10.1177/0894318407307160
- Parse, R. R. (2014). *The Humanbecoming paradigm: A transformational worldview*. Pittsburgh, PA: Discovery International Publication.
- Patterson, E., Hart, C., Bishop, S. E., & Purdy, N. (2013). Deciding if home care is right for me: The experience of the new graduate nurse. *Home Health Care Management Practice*, 25(4), 47-154. doi: 10.1177/1084822312473828
- Piela, A. (2015). Videoconferencing as a tool facilitating feminist interviews with Muslim women who wear the niqab. *Digital Methodologies in the Sociology of Religion*, eds. S. Shakkour and S. Contractor. London: Bloomsbury. Retrieved https://www.academia.edu/Documents/in/Qualitative_Interviewing_Using_Skype

- Qiao, G., Li, S., & Hu, J. (2011). Stress, coping, and psychological well being among new graduate nurses in China. *Home Health Care Management & Practice, 23*(6), 398-403. doi: 10.1177/1084822311405828
- Rilke, R. M. (1993). *Letters to a young poet* (M. D. Herter Norton, Trans.). (rev. ed.). London; Norton. (Original work published 1903-1908).
- Rousseau, J. (1979). *Emile*. New York: Basic Books.
- Rudestam, K. E., & Newton, R. R. (2007). *Surviving Your Dissertation: A Comprehensive Guide to Content and Process*. Thousand Oaks, CA: Sage.
- Schofield, R., Ganann, R., Brooks, S., McGugan, J., Bona, K. D., Betker, C., Dilworth, K., Parton, L., Reid-Haughian, C., Slepkov, M., & Watson, C. (2011). Community health nursing vision for 2020: Shaping the future. *Western Journal of Nursing Research, 33*(8), 1047-1068. doi: 10.1177/0193945910375819
- Shah, T. M. (2013). Chaos and fear: Creativity and hope in an uncertain world. *International Sociology Reviews, 28*(5), 513-517. doi: 10.1177/0268580913496920
- Sieber, J. E. (1992). *Planning ethically responsible research: a guide for students and internal review boards*. Thousand Oaks, CA: Sage.
- Simon, M. K. (2011). Validity and reliability in qualitative studies. *Dissertation and Scholarly Research: Recipes for Success*. Retrieved from <http://dissertationrecipes.com/wp-content/uploads/2011/04/Validity-and-Reliability-in-a-Qualitative-Study.pdf>
- Sneltvedt, T., Odland, L., & Sorlie, V. (2010). Standing on one's own feet: New graduate

- nurses' home health care challenges and work experiences study. *Home Health Care Management & Practice*, 22(4), 262-268. doi: 10.1177/108422309341256
- Sneltvedt, T., & Sorlie, V. (2012). Valuing professional pride and compensating for lack of experience: Challenges for leaders and colleagues based on recently graduated nurses' narratives. *Home Health Care Management & Practice*, 24(1), 13-20. doi: 10.1177/1084822311412592
- Strauss, A. (1987). *Qualitative analysis for social scientists*. New York: Cambridge University Press.
- Tesch, R. (1990). *Qualitative research: Analysis types and software tools*. New York: Falmer.
- United States Department of Health and Human Services [HRSA]. (2014). *The future of the nursing workforce: National- and state-level projections, 2012-2025*. Retrieved from <http://hrsa.gov/healthworkforce/index.html>.
- Yancy, N. R., (2005). The experience of the novice nurse: A humanbecoming perspective. *Nursing Science Quarterly*, 18(3), 215-200. doi: 1177/0894318405278500.
- Young, S., Acord, L., Schuler, S., & Hansen, J. M. (2014). Addressing the community/public health nursing shortage through a multifaceted regional approach. *Public Health Nursing*, 31(6), 566-573. doi: 10.1111/phn.12110

Appendix A: Interview Protocol

1. What is it like to feel fearful?
2. How does feeling fearful affect your routine?
3. How does feeling fearful affect your relationships?
4. What are your concerns and plans?
5. What are your hopes and dreams?
6. Is there anything you would like to add?

Appendix B: Recruitment Flier for Participants

YOU ARE THE FUTURE OF NURSING!

HELP CREATE POSITIVE CHANGE BY PARTICIPATING IN A NURSING
STUDY!

My name is XXXXXXXX and I am a doctoral student with Walden University! For my dissertation, I am conducting a research study about feeling fearful. The population is graduate nurses in Community/Public health. This is an opportunity to let your voice be heard! If you are interested in participating in my study, let your facility contact person, supervisor, or nursing director know and you will be given a short questionnaire to establish that you meet the criteria for the study. If you are selected, you will be invited to participate in this short study. Your participation is voluntary and you will be asked to provide informed consent which allows you the opportunity to ask questions and understand the study before making a final decision to participate.

Sincerely,

XXXXXXXXXX

Walden University

Your Point of Contact is:

XXXXXXXXXXXX

Phone/EmailXXXXXXXX

Appendix C: Transcriptionist Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

Name of Signer: Name undisclosed

During the course of transcribing audio recordings of interviews for this research study entitled: “The Meaning of Feeling Fear for New Nurses in Community/Public Health”.

I will have access to information which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant. By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant’s name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification, or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.

6. I understand that violation of this agreement will have legal implications.

7. I will only access or use systems or devices I'm officially authorized to access; and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: signature undisclosed

Date:

Appendix D: Research Community Partner Agreement

Date

Dear Demetrius Jones,

Based on my review of your research proposal, I give permission for you to conduct the study entitled The Meaning of Feeling Fear for New Nurses in Community/Public Health

within the XXXXXXXX. As part of this study, I authorize you to recruitment, set up interviews for data collection, member checking, and results dissemination activities.

Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: a classroom setting for private interviews. A faculty advisor will be assigned to you as part of our agreement. We reserve the right to withdraw from the study at any time if our circumstances change.

The student will be responsible for complying with our site's research policies and requirements,(Describe requirements. Will be added here)

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,
Authorization Official
Contact Information

Appendix E: Consent to Release Manuscript for Publishing

(Date)

Dear XXXXXXXXXX

Once again, I wish to thank you for participating in my study. I have completed the writing of the manuscript and would like your permission to release the study for publication. Enclosed is a draft copy of the dissertation that will be released for publication following my oral defense during XXXXXXXXX. There are minor editing changes needed prior to the release, however, the personal narrative section is verbatim and will appear in the publication as written in the enclosed draft. As previously discussed during your signing of the original consent form, every effort was made to provide for confidentiality. However, there is a risk with narrative interviews that personal identity might be exposed through the very nature of your personal experience. Please review the enclosed draft, focusing in particular on your personal narrative. If, after reviewing the narrative, you agree to the release of the manuscript, please sign below acknowledging your consent for the release of this manuscript for publication.

I _____ have read the above information. I have asked questions, received answers, and willingly authorize the release of the study “The Meaning of Feeling Fearful for New Nurses in Community/Public Health”.