MENTAL WELLNESS: A CONCEPT ANALYSIS

By

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Executive Summary

Wellness is a current media buzzword popularly used to promote healthy lifestyles. This focus of wellness is generally geared toward a healthy diet and exercise, and is simplistically taken to mean the opposite of illness. Yet the concept of wellness is much broader than health, which implies only the absence of disease in the physical body. A concept analysis as described by Walker and Avant (2011) was applied to the term mental wellness to determine its meaning beyond a standard dictionary definition. In the nursing metaparadigm, *person* is viewed as a triune being consisting of body, soul, and spirit, and the nurse practicing holistic care attends to the physical, mental, emotional, and spiritual needs of the patient (Watson, 1999). Thus, wellness also must encompass the entire person by considering the state of the spirit and soul of an individual as well as their physical body. A state of wellness is more than merely the absence of disease; and implies a holism that is greater than the sum of its parts.. While wellness has been readily accepted in relation to the physical body, it has not been largely used in relation to the soul and spirit. In fact, the constructs of soul and spirit, emotion, will, and thought are often condensed by societal and professional norms into the single term "mental." Indeed, instead of mental wellness, one hears of mental illness or mental health. A concept analysis of the term mental wellness resulted in an operational definition stating mental wellness was the sum of spirit, soul, and body working in harmony as it is influenced by relationships, community, thoughts, intellect, and environment. The concept analysis commenced for the purpose of developing a faith based nurse managed wellness center with an emphasis on mental wellness.

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Background

One of the most stigmatized illnesses worldwide is mental illness. The cost related to treating mental illness continues to be staggering with depression as the third largest burden of care worldwide. The World Health Organization (WHO) has predicted depression to be the number one burden by 2030 (WHO, 2012). According to the Centers for Disease Control and Prevention (CDC, 2013), depression is a significant contributor to the global burden of disease, which includes healthcare costs, morbidity, and mortality; it affects people in all communities across the world. Depression was estimated to affect 350 million people in the year 2013. The World Mental Health Survey conducted in 17 countries found that on average about 1 in 20 people reported having an episode of depression in the previous year (CDC, 2013).

According to Gask, (2003), most mental health problems have been treated by primary care providers in the US. These care givers delivered the pathway for mental health care, and provided interventions for management and detection of depression. Depression has been recognized more and more as a common treatable illness, but has also carried with it the potential of being chronic or even fatal. Fatalities were primarily related to suicide and the comorbid depression that accompanied a physical illness such as renal failure or coronary heart disease.

The estimated lifetime prevalence in the general population in the United States of any anxiety disorder was over 15%, while the 12-month prevalence was more than 10% (CDC, 2013). Bipolar disorder has been deemed the most expensive behavioral health care diagnosis, costing more than twice as much as depression per affected individual.

Total costs largely arose from indirect costs and were attributable to lost productivity, in turn arising from absenteeism and presenteeism (non-productivity while at work). Schizophrenia has worldwide prevalence with estimates ranging between 0.5-1.0%. Based on these statistics, it is not difficult to see the burden of care from mental illness placed not only on the healthcare system, but also on society as a whole. Socrates once stated, "There is no illness of the body apart from the mind" (Rankin, 2013). To ignore mental wellness is to ignore wellness. According to the Institute of Medicine (IOM, 2008), current health care frameworks generally failed to stress wellness. The biomedical model dominated health care, creating a deficit in holistic care that addressed the entire person spirit, soul, and body (Kirsten, Van der Walt & Viljoen, 2009).

Purpose

The purpose of this paper was to determine the operational definition of the term mental wellness through a formal concept analysis in the format proposed by Walker and Avant (2011). The operational definition of mental wellness was used in proposing a new practice model: Faith-Based, Nurse-Managed Wellness Centers (FBNMWC). These will be focused on mental wellness. Also addressed in this paper were the goals to help establish the wellness center, the potential impact on health care, and the impact the study had on the author both personally and professionally.

Goals

The primary goal of this project was to develop a clear and concise definition of the concept of mental wellness. After arriving at the operational definition of mental wellness, a new nursing practice model will be proposed to incorporate the concept of mental wellness in a FBNMWC. In creating the FBNMWC model of care, other goals

included identifying the need for such service, which specific services were to be provided, how to provide access to care, and a method to develop an interdisciplinary team approach.

Faith-based Nurse-managed Wellness Center Concept

The nurse-managed wellness centers concept will provide the opportunity to design a system that administers much needed services to a much-maligned, underserved population. According to Zwitter (2013), emergency departments have been utilized as primary care providers for many mentally ill individuals. Zwitter also stated that 32% of the severely persistent mentally ill had not seen a primary care provider and that more than 80% of the mentally ill had medical comorbidities. In addition, this group tended to have a life span of 25 years less than that of the average population. Kliff (2013) stated that the average cost of an emergency department visit cost 40% more than a month's rent.

Carolla (2004) reported

> two-thirds (67%) of emergency physicians attribute the recent escalation of psychiatric patients to state health care budget cutbacks and the decreasing number of psychiatric beds. One in ten reports there is nowhere else in the community where people with mental illness can receive treatment (p. 3).

In addition, there was a practice occurring in emergency departments labeled as boarding. Boarding occurred when mentally ill patients were admitted to the hospital and forced to remain in the emergency department until a hospital bed became available (Carolla, 2004). Creswell (2013) reported that many mentally ill patients did not have a medical complaint, when accessing the emergency department, but were just living on the

street and looking for some help.

Another population that suffered from a lack of care was children. Sawyer (2013) stated that the most prevalent childhood problem was anxiety affecting 2.2 to 9.5% with less than one third seeking treatment. Left untreated, these children were at risk for mental health problems later in life.

One of the goals identified in the United States Department of Health and Human Services (HHS), Healthy People 2020 (2011) was to eliminate health care disparities or inequities. Lack of access to quality health care inhibited personal growth and quality of life. Prohibitive cost, lack of insurance and unavailability of services were all major barriers to seeking health care (HHS, Healthy People 2020, 2011). As a result, in Healthy People 2020, it was stated that these barriers led to unmet health needs, delays in seeking care, and an inability to receive preventative services. Braveman (2014) stated that "Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at the greatest risk of poor health, based on social conditions". Hansen-Turton, Miller and Greiner (2009) also wrote that,

> Barriers to treatment that exist for disadvantaged groups, particularly women, include poverty, lack of health insurance, and lack of transportation and/or child care, as well as the stigma and shame attached to receiving behavioral health services. For many people mental health problems are associated with "being crazy" or weak, and patients believe that by trying harder they can will away or pray away mental health problems (p 80).

The FBNMWCs were designed to be strategically placed in underserved communities to

provide most preventative services. Furthermore, FBNMWCs would help expedite access to the appropriate providers and would help prevent any further potential deterioration of physical condition. Ultimately, students from nursing and other professions were made available to provide the clinic services.

The wellness model developed by Myers, Sweeney and Witmer (2000), identified five life tasks for mental health. These tasks were: “essence or spirituality, work and leisure, friendship, love, and self-direction”. Self-direction was further divided into subtasks, consisting of: sense of self-worth, sense of control, realistic beliefs, environmental awareness and coping, problem solving and creativity, sense of humor, nutrition, exercise, self-care, stress management, gender identity, and cultural identity (Hansen-Turton, Miller, &Greiner, 2009). The FBNMWCs were designed to provide services to support those tasks and sub-tasks. These centers would promote optimal individual mental health through screening, education, spiritual care, and general emotional and physical support.

Services Provided

The next goal addressed was the identification of services provided. Services that would be offered within the FBNMWC included biometrics. This category would provide health information through monitoring blood glucose, hemoglobin A1C, cholesterol, and triglycerides. These would be obtained through a finger stick, with results in less than 20 minutes. Vital signs, body mass index, height and weight also would fall into this area (Zwitter, 2013).

Health screening would also be available to the patrons of the clinic. Within this context, nurses would perform developmental screening on infants, children and

adolescents. Medical screening for sports and camps were another area of perceived need. Standard screening for hypertension, diabetes, weight management, skin lesions, and breast and testicular cancer were some other areas that could be easily addressed. When needed, nurses would visit homes for environmental assessment to decrease exacerbations of diseases such as asthma or evaluate places of residence for other hazards. Included in client screening would be a mental health assessment that incorporates vetting for depression, stress, substance abuse, suicidal ideation, the presence of hallucinations, and a global functioning scale, using assessment tools such as the Personal Health Questionnaire 9 (PHQ-9), displayed in appendix A.

As a result of biometrics and health screening, an individual wellness plan would be developed. Addressed in this plan would be health teaching and coaching to promote optimal wellness for each person. Partnership between the FBNMWC personnel and the clients would lead to the development of obtainable realistic goals set by the clients with the support of staff. Areas of focus would include but not be limited to weight loss, medication compliance, stress management and ability to recognize the early exacerbation of an illness.

After establishing credibility and relationships with the primary health care community, referrals would be made for clients needing further assistance beyond the scope of the wellness center. This would assure access to the health care system for clients who may have not otherwise been known, or for those who did not know how to become a part of a primary care service. The need of meeting total health care needs of the patient would be a desired outcome.

Mental health patients struggle with diet and exercise, as do most other people.

Unfortunately, many psychotropic drugs are associated with weight gain. In addition, because of low socioeconomic status or lack of adequate living spaces, many of the mentally ill were prone to eating unhealthy fast food (Zwitter, 2013). The FBNMWCs would provide nutritional information and cooking classes along with structured exercise classes to promote optimal health even in the throes of chronic illness.

Student Clinical Experience

What would also be exciting about establishing a FBNMWC would be the opportunity to apply a multidisciplinary approach to care. The utilization of student nurses provides an opportunity for these students to hone their assessment skills, to provide patient education, and to improve communication skills in conjunction with critical thinking. In addition to nursing students, psychology students for psychotherapy, education majors for teaching techniques, nutrition students for balanced eating and cooking instruction, and physical education majors for fitness and exercise programs would play an important role in the overall health promotion and optimal wellness focus of the wellness center clientele.

Establishing a Clinic

The last goal addressed in this paper would entail establishing an actual clinic. The FBNMWC would provide care throughout the year by utilizing traditional undergraduate pre-licensure registered nurse students and post-licensure students who were continuing in education to receive their Bachelor of Science degree in nursing, commonly called RN to BSN. The mental wellness model would be incorporated into the school of nursing curriculum. The wellness center could be designed to meet the core competencies in community/public health, mental health, and health promotion clinical

rotations, thereby lessening the burden at other clinical sites.

The obvious barrier to starting and maintaining a FBNMWC would be the cost. Fortunately, grant money is available through the Health Resources and Services Administration (HRSA), utilizing the Nursing Education, Practice, Quality and Retention (NEPQR) Grant. Purpose Two of the grant stipulated that money would be used for "providing care for underserved populations and other high risk groups such as the elderly, individuals with HIV/AIDS, homeless, substance abusers, and victims of domestic violence" (HRSA, 2014, p. 1). Any of the above groups were at risk for mental illness. Other funding that complemented these grants would come from financial assistance, from the university housing, from the school of nursing and from local churches that have an interest in being active in the health care of the community. The wellness center would also seek assistance from laboratories and providers of medical equipment, to keep costs for administering and processing tests to a minimum. Fees for services would be based on a sliding scale. No client in need would be denied services.

Potential Impact on Healthcare Practice

A significant potential impact on healthcare would be to decrease the number of mentally ill clients who used the emergency departments (ED) at local hospitals in the community. Eliminating the unnecessary visits to the ED would free up healthcare providers to treat critical individuals requiring emergency services. Mentally ill clients would need to learn to access the ED only under the circumstances of a true physical emergency, thereby decreasing overall healthcare costs.

The FBNMWCs would also provide many avenues of care at the point of service. In essence, the wellness centers would provide one-stop shopping for its clientele by

providing healthcare, counseling, exercise, nutritional support, and even haircuts or other basic hygiene needs. Many of the mentally ill do not otherwise have access to showers, cooking supplies or haircuts.

Providing care with a mental health emphasis would allow the wellness centers to invest in disenfranchised people and help them feel valued, thereby increasing their self-esteem. As a consequence of increased self-esteem, better compliance would be seen with the individualized health plan. Mental wellness would be a part of the total health care plan.

Personal and Professional Impact

> Go to the lost, confused people right here in the neighborhood. Tell them that the kingdom is here. Bring health to the sick. Raise the dead. Touch the untouchables. Kick out the demons. You have been treated generously, so live generously (Matthew 10:6-8, The Message Bible).

The desire of this author is to operate in the power of Christ as indicated in Matthew, chapter 10. What an honor and responsibility to go to the confused and untouchables in the neighborhood and to bring health to the sick. The question that was asked was, what does this look like in modern day America? The answer was a Faith-Based, Nurse-Managed Wellness Center. Jesus went out to the people and did not require the people to come to seek Him. He made Himself available to those who needed Him. The purpose of a FBNMWC is first and foremost to present the gospel. This would not necessarily be done through traditional preaching, but through Christ-like love and speaking the truth in love. In the third book of John, he wrote, “Beloved, I pray that in all respects you may prosper and be in good health, just as your soul prospers” (3 John 1:2). This indicated a

direct correlation between physical and mental health. To address one without the other would be similar to performing surgery without closing a wound, or treating an infection with pain medication. The author, as a pastor and a nurse, recognized that the FBNMWC provides a marriage for the two professions and callings.

A wellness clinic also provides the opportunity to model an alternative form of health care other than the medical model. Although the medical model has been remarkable in what it does, health promotion and wellness were not deeply incorporated into its paradigm. Wellness centers may be an amazing opportunity for nursing to be the forerunner in health care reform and demonstrate a health promotion wellness paradigm. Through effective health promotion and wellness, nurses could perhaps demonstrate significant cost-saving healthcare that may eventually lead to fiscal reimbursement for these services.

Obtaining experience as a mental health provider through clinical opportunities is necessary for this author to accomplish these goals. Such opportunities are available through the Shasta County Mental Health, Alcohol, and Drug inpatient services and through Restpadd, Inc., the newly established inpatient mental health facility. With enough accrued clinical experience the nurses will be eligible to take the mental health advanced practice certification exam.

Theoretical Framework

What does it mean to be human? Phrases such as “I am only human” or “To err is human” are often used, but these do not describe what it means to be human. Through the eyes of a nurse, many types of humans are seen as they come through the health care system. Biologically speaking, these individuals are often referred to by the nature of

their injury or illness. From a psychological paradigm, humanness is determined by behavior. The sociological value of the person is frequently related to health care coverage. Advanced practice nurses, in order to provide appropriate care for clientele, must determine a personal definition of what it means to be human and to be healthy and to explore the relationship between the two, especially as it relates to mental health and illness.

Watson (2004), in her theory of human caring, defined a person as "mind-body-spirit oneness; person-nature-universe oneness" (p. 147). Shelly and Miller (2006) defined a person as "a transpersonal, transcendent, evolving consciousness" (p. 49). Watson expanded on the definition of a person through transpersonal caring, which was a result of being intentional to connect with another through the act of caring (Zaccagnini & White, 2014). What was impressive about this particular theory was seeing the relationship between human to self, human-to-human and human to environment. Because of the relational aspect of Watson's theory, it was adaptable to caring for persons suffering from mental illness (Boyd, 2008).

Defining health encompassed individuals, families, and communities. The relationships between these entities were important in determining not only what health was, but also what influenced health. Traditionally, health has been placed on a continuum with illness at one pole and wellness (or the absence of illness) at the other. Shelly and Miller (2006) broke down Watson's philosophy and science of caring, and saw health as "consciousness; human- environmental energy field" (p. 49). What seemed to be lacking here was concreteness in the definition. Nebulous ideas led to nebulous results. The preferred definition for this writer comes from the Hebrew word *shalom*

which, when translated into English, means “wholeness, completeness, or fulfilledness” (Wagner, 2004, p. 125). Only individuals could define their personal state of health or completeness. The nurse’s role was through relationship and partnership to assist the patient in finding that individual meaning.

Applying these principles to a FBNMWC with an emphasis on mental health provides access to care for an extremely vulnerable population that generally falls through the proverbial cracks. Advanced practice nurses have filled these cracks by providing care to a class of human beings who were stigmatized and lacked access to care. This could have easily led to less complex and complicated outcomes.

Nursing Theory. From a historical context, health care in the United States had been approached from a medical or diseased-based model, which caused people to seek health care when annoying physical symptoms occurred. As a result, health care costs became staggering, with over 47 million nonelderly uninsured people nationwide (Health Reform, 2014). Illness has always persisted, but how does wellness assume the front running position in health care?

Pender, after earning her bachelor of science in nursing and doctor of philosophy in psychology and education, developed and published her health promotion model (HPM) in her textbook, *Health Promotion in Nursing Practice* in 1982 (Butts and Rich, 2011, pp. 404). Incorporated into this multidimensional model was social learning theory which defined how cognitive processes affected behavioral change, and theory of reasoned action which related how personal attitudes’ affected behavior (Butts and Rich, 2011). According to Pender, Murdaugh, and Parsons (2011),

> The initial HPM stimulated studies to describe the potential of seven cognitive-perceptual factors and five modifying factors to predict health behaviors. The cognitive factors were importance of health, perceived control of health, definition of health, perceived health status, perceived self-efficacy, perceived benefits, and perceived barriers. The modifying factors are demographic and biological characteristics, interpersonal influences, situational influences, and behavioral factors (p. 44).

Based on these constructs, the advanced practice nurse (APN) had the opportunity to learn how patients understand personal health and wellness. The APN used open-ended questions related to Pender's seven cognitive perceptual factors and five modifying factors, such as "What does it mean to be healthy?", or "What do you do to be healthy?" This led to more than a single-word answer. Based on the response, the APN collaborated with the client to develop a personal wellness plan. Through these answers, health behaviors were identified, which lead to the determination of what patterns needed to be addressed to help establish or maintain a healthy lifestyle.

Research indicated that previous behavior was a predictor of future behavior (Pender, Murdaugh, and Parsons, 2011. p. 44). Understanding repetitive behaviors and experiences helped both the health care provider and client to understand why patterns did not change without intentional intervention. Setting obtainable goals and accessibility to follow-up care for accountability provided the impetus and power to make healthy choices. In every visit, it was imperative for the APN to address the collaborative goals to assess progress, regress, and reevaluate effectiveness. The overarching goal was

high-level wellness for the clients and decreased comorbidity from other factors related to chronic conditions.

Change Theory. An old definition of insanity is doing the same thing over and over and expecting different results. The purpose of change is to make an effort to achieve different results. Having said that, it would be remiss not to mention that change can be very difficult. The difficulty is often found in what Lewin describes as the unfreezing process or destabilization of old behaviors (Butts and Rich, 2011, pp. 357-358). Once this has occurred, those involved can move towards a more acceptable behavior and then to the refreezing stage that allows the new behavior to become a part of normal activity (Butts and Rich, 2011).

Interdisciplinary Theory. An integral piece to wellness was the concept of learning. Learning occurred at many levels and through varied experiences and perceptions. Cognitive learning theory incorporated learning from a psychosocial and perceptual aspect in addition to cognitive behavior. Butts and Rich (2011) wrote that "Cognitive learning theory focuses on the perceptions, thinking, reasoning, memory, and developmental changes that transpire within the learner" (p. 213). Furthermore, learning was an active process that was influenced by what the learner perceived, how the experience was interpreted, the learner's response to the environment, and social factors influencing how the learners constructed reality (Butts & Rich, 2011). The implication was that all things seemingly being equal, there was still a possibility that what was being said by one person may not be what was heard by another, due to individual thoughts, perceptions, reasoning, thinking, and experiences. Problems occurred when negative thinking dominated an individual, and subsequently negative behavior ensued. To

combat this problem, Cognitive Behavioral Therapy (CBT) was introduced in the 1970s by Dr. Beck (Freeman-Clevenger, 2012). Cognitive Behavioral Therapy was defined as "a type of psychotherapy in which negative patterns of thought about the self and the world are challenged in order to alter unwanted behavior patterns or treat mood disorders such as depression" (Butler, Chapman, Forman & Beck, 2006, p. 18). Dr. Amen (2002) defined cognitive therapy as "therapy for your thoughts" (p 156).

Cognitive Behavioral Therapy (CBT) was used for self and personal growth. Additionally, CBT was also studied extensively in the mental health setting, especially with mood, anxiety, excessive compulsive, and panic disorders (Warren, 2012). Kurtz (2012) developed a study using CBT as a treatment for insomnia. The results indicated a 20% reduction in wakefulness after sleep and a 50% reduction in medication usage. According to, Sawyer (2013), anxiety was the most common mental illness in children and CBT was recommended as a first-line treatment for children with anxiety disorders.

The goal of CBT was to teach the client to identify and replace automatic negative or maladaptive thoughts (Warren, 2012). Relapse prevention was the next step and was achieved by role-playing anticipated future stressful life events that triggered future anxiety or depression (Warren, 2012). Role-playing provided a safe environment to practice positive behavior changes.

Summary

Through establishing a solid and concrete definition of mental wellness, a new nursing model will be implemented for those who seemed to fall through the cracks of the current healthcare system. This model then would be applied to establish a FBNMWC with an emphasis on mental wellness. The FBNMWC would be an

opportunity to meet basic health care needs for underserved populations who experienced mental illness with other possible comorbidities. The wellness center would then provide access to care and expedited entry into the primary care system as necessary. Through combining Watson's and Pender's nursing theories, Lewin's change theory, and cognitive theory, an interdisciplinary approach was applied to the concept analysis of mental wellness to provide the best practice model possible to provide care for those seeking to obtain their maximum mental wellness.

Chapter Two

Meta-Synthesis of the Literature

The World Health Organization (1948) has defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (Wand 100). According to this definition, mental health was inextricable from physical, spiritual, and social or environmental health. Otherwise stated, to be healthy, one had to be whole in spirit, soul and body. To be lacking in any one of these areas was to compromise health. Manderscheid et al. (2010) indicated a paradigm shift in mental health from a diagnosis to a person-focused definition of mental illness and absence of disease, and then to an emphasis on positive psychological functioning in relation to mental health. Kirsten, Van der Walt, and Viljoen (2009) described wellness as unity between spirit, soul and body while also incorporating environmental factors in the context of the natural, social, and cultural arenas. According to Duncan (1987),

> When we use the term health, we are usually speaking about illness. This has given rise to such terms as good health, positive health, and wellness. A serious examination of wellness suggests that mental wellness may be at the core of wellness (p. 3).

Wand (2013) further added that positive health did not discount and ignore the negative aspects of life, but tried to reframe these negative experiences as having value for growth, handling adversity, and engaging creativity to find ways of maintaining wellness. Traditionally, mental health had been treated from a medical model that focused on dysfunction rather than function or illness rather than wellness. In light of the more common approach to treating mental disorders, perhaps it was time for a different way to

view mental health. Wand (2013) had described the emerging discipline of positive health as an asset-based paradigm with direction toward fostering psychological resilience. Resilience was a concept that manifested itself through the development of positive adaptation through adverse situations or threats that assisted individuals to conquer and adapt to life's challenges (Wand 2013).

Historically, when a person had exhibited signs and symptoms of mental illness, the patient, in addition to others near the patient, had become frightened. As a result, many of these individuals demonstrating symptoms had been coerced into treatments that made them behave and feel the way others thought they should (Copeland, nd). Many of these mental health treatments had been centered on pharmacotherapy. Pharmaco-centrism had, in many circumstances, allowed marketing to overtake science, in spite of lack of evidence regarding efficacy of psychotropic medications and the high prevalence of debilitating long-term side-effects (Barker & Buchanan-Barker, 2006; Lakeman & Cutcliffe, 2009). According to Copeland (nd), research had indicated that people in the public mental health system had a life expectancy of 25 years less than that of the general public, due to the severe side effects of these medications. Keogh et al. (2014) quoted from a facilitator in their Wellness Recovery Action Plan (WRAP) program who said "Not a lot of consultants would be interested in what we are doing. They are still looking at a medical model. And I suppose we as practitioners in developing, it's part of our mission statement to educate them." (p.194)

The purpose of the study was to perform a concept analysis approach for proposing a new practice model: Faith based, nurse managed wellness center focusing on mental wellness. Concept analysis consisted of the establishment and interpretation of a

mental construct, methodized significant information, which facilitated and augmented the details which promoted ideology and served as a rudder for the praxis of the concept (Weaver & Mitcham, 2008).

Review of Literature

This paper was a meta-synthesis of literature that detailed mental wellness and was by no means exhaustive (see Table 1). According to Holloway and Wheeler (2010), the qualitative account had broadly revealed knowledge that already existed and tended to be more limited than in other types of literature. Patton (2002) had written that there was a risk in doing a literature review before the study was complete because qualitative inquiry may have caused bias to thought process and decreased the openness to what may have actually been revealed in the field. The evaluation of previous studies and publications provided an opportunity to approach the subject from a multidisciplinary perspective. As a result, information was found that related to the development of the concept of mental wellness.

The literature search was conducted using CINAHL (Cumulative Index of Nursing and Allied Health Literature), PsycArticles, and PsycInfo (American Psychological Association) data bases. Two search terms were used in combination. These were *mental wellness*. The initial broad search yielded approximately 600 citations, which was narrowed to eight based on title review, specific use of the term mental wellness, abstracts, peer review, qualitative studies, and triangulated studies. Included in determining the studies reviewed was that the purpose of the research was clearly stated, as was the methodology utilized to collect and analyze data. Also needed

were description of participants and the setting. Finally, the results of the study had to include narratives from the data.

The eight studies reviewed covered the time span of 2005 to 2014. The studies primarily dealt with defining or enhancing mental wellness. Six of the reviewed studies addressed specifically a mental health wellness recovery action plan or WRAP. One study was related specifically to staying well with bipolar disorder. Another was about wellness in an adult day care center. An additional study evaluated the prevalence of depression on a lower socioeconomic neighborhood. Table 1 on page 23 summarizes the eight studies.

Meta-Synthesis

After the literature was reviewed, a line-by-line coding was performed, which identified themes associated with the data collection from qualitative studies. Four major themes were discovered as a result of the coding process.

Theme one. The first common theme was the concept of wellness/recovery. The focus was on establishment or maintenance of wellness through recovery. Much of wellness and recovery was centered on mental health consumers participating in a Wellness Recovery Action Plan (WRAP).

A WRAP was used by facilitators to partner with members so that the members could obtain and maintain successful wellness by determining to improve, taking ownership of their recovery, dealing with problems, and making choices (Sterling, von Esenwein, Tucker, Fricks, & Druss, 2010). A powerful concept recognized by those who partook in a WRAP program was wellness as an ongoing process and obtainable goal

(Cook et al., 2010; Pratt, MacGregor, Reid,& Given. 2012). One client was quoted as saying:

Table 1: Summary of Investigations of Mental Wellness Studies

Author and Location	**Study purpose**	**Method/sample**	**Major findings**
Bluthenthal et al. (2006); USA	Developing mental wellness awareness related to depression in individuals and communities	Qualitative : Self-administered questionnaire, field notes, and qualitative interviews N= 63	Depression described as an individual and community problem. Needed intervention was talk to de-mystify depression, build community strength and services, and support through policy and advocacy for vulnerable populations
Cook et al. (2010); USA	Self-management of mental illness taught by peers to people in mental health recovery using a Wellness Recovery Action Plan.	Qualitative: anonymous written feedback N=381 Quantitative: pre-, post-test, utilizing two-tailed *t*-test	Wellness was obtainable, as was growth in support networks, new knowledge and skills for mental wellness Quantitative results significant with $p<0.05$
Higgins et al. (2012); Ireland	Evaluation of Wellness Recovery Action Plan	Qualitative: focus groups Quantitative: questionnaires, paired sample *t*-test N=67	Life plan as opposed to an illness recovery plan; empowerment, increased self-belief and capacity for wellness and recovery. Quantitative: improved knowledge and attitudes between pre- and post-test with $p<0.0001$
Keogh et al. (2014) Ireland	Effectiveness of a mental health Wellness Recovery Action Plan education	Qualitative: focus group post educational program using semi-structure interview	Enhancing knowledge and skills r/t WRAP, facilitation of WRAP, empowerment r/t WRAP
Marchinko and Clark (2011); Canada — Utilization of mental health wellness planner	Qualitative: Semi-structured interviews N=42	Empowerment, self-advocacy	

Pratt, MacGregor, Reid, and Given (2012); Scotland	Assess relevance and impact of WRAP in group settings, as a tool for self-management and wellness	Qualitative: focus group and facilitator interviews N=8	Mutuality, on-going process, personal responsibility for wellness
Russell and Browne (2005); Australia	Effectiveness of stay well plan with persons diagnosed with bipolar disorder	Qualitative: written by participant or collected through personal interview N=100	What staying well meant, Acceptance of diagnosis, being mindful of having bipolar disorder, being educated about bipolar disorder, identified and addressed triggers, recognized warning signs of decompensating, management of sleep and stress, alternative treatments, access support, importance of having a stay-well plan
Valadez, Lumadue, Gutierrez, and de Vries-Kell (2006) USA	The effects of Adult day care centers on the emotional state of elderly Hispanic women	Qualitative: semi-structured that mirrored everyday conversations N=24	The adult day care center provided activities, socialization, spiritual, support, in a cultural context resulting in decreased reports of loneliness and depression

> This course helped me see that there are options for me in how I live my life with my problems, and that recovery and health happen by degrees, with steady effort; that supporting and being supported by friends, etc. is really just one of the most integral parts of anyone's life (Cook et al., 2010. p. 118)

In another study by Pratt, MacGregor, Reid, & Given (2012), a participant in a WRAP program stated:

> I think the WRAP program gives you a program for life, a program of recovery, but it's like a never-ending process; you don't do it and then say well that's done now I don't have to do it anymore. It's an ongoing thing, it's something you add or take away as you progress. And I think it's very good (p. 404).

One rationale related to a WRAP program was to take away the medicalization of recovery by avoiding terminology such as compliance, relapse, diagnosis or symptom, and other terms associated with illness (Higgins et al., 2012). This study also showed that, as a result of a WRAP program, the researchers felt it helped to send a message not

only to the participants, but to others as well, that people could have positive productive lives and even recover from mental illness. Russell and Browne (2005) identified their main finding, in order to maintain wellness with bipolar disorder, having a plan to sustain wellness could deter illness. Keogh et al. (2014) added, from one of the participants in their study, regarding involvement in a WRAP program, "everyone is in the process of recovery" (p. 191).

Theme two. Support was another dominant theme woven throughout the eight studies regarding mental wellness. Wellness required a range of support networks to maintain stability (Russell & Browne, 2005). Bluthenthal et al. (2006), in the Witness for Wellness (W4W), discovered that support systems included relatives, close friends, medical professionals, mental health workers, clergy, media, and the community. The study examined the important question of who was responsible for addressing depression. The responses implied that individuals and the community had the duty to beat depression. Participants emphasized how crucial it was to educate the community on the availability of resources within the community and to provide information of those qualified to help with wellness and recovery (Bluthenthal et al. 2006). Maintaining wellness was linked to knowing when and who to ask for help (Russell & Browne, 2005).

One simple concept relevant to support was found to be socialization. When interviewing elderly Mexican-American females at an adult day care center (ADC), Valadez, Lumadue, Gutierrez, and deVries-Kell (2006) learned that although personal activities may have been fulfilling, the absence of other people had a negative effect on well-being. To complement this, others reported the ability to associate with more positive people and to realize that they were not the only individuals dealing with mental

health problems improved their outlook (Cook et al. 2010). Facilitators of a WRAP program were also perceived as being more supportive if they were also adhering to their own wellness plan (Pratt, MacGregor, Reid & Given, 2012).

Theme three. Further review of research identified the role of individual stressors and triggers as an integral part to mental wellness. To be aware of decline in mental wellness, people needed to be aware of their response to their moods and environment (mentally, physically and socially), and to intervene with strategies to avert an episode of illness (Russell & Browne, 2005). Although early warning signs varied between individuals, early identification and intervention could prevent relapse. Russell and Browne (2005), found common stressors in their population were related to stress, sleep, jet lag, substance abuse, and changes in hormonal levels and seasons. As a result, it was important to maintain mental wellness and for participants to pay careful attention to subtle changes in sleep cycles, attitude, thoughts, and levels of energy.

After developing a wellness plan through the WRAP program, participants were able to better recognize and address stressors and triggers (Cook et al., 2010). As expressed by one contributor with bipolar disorder, “I feel I am beginning to understand how to manage the symptoms of depression and mania through this system-recognizing the early warning signs and strategies for dealing with them.” (p.118) Another’s response to triggers was “I now use my response to triggers and early warning signs when before, I thought they were [signs I was already in] crisis.” (p.118)

Theme four. The fourth theme that surfaced during the review process was empowerment. Included in empowerment were behaviors such as self-management, self-control, self-awareness, self-advocacy, and self-support. Basically, empowerment

allowed for individuals to take charge of the outcomes of wellness. The previously discussed themes were possible because self was expressed through personal choices such as wellness plans, support systems, and dealing with stressors and triggers. Keogh et al. (2014) noted, when reflecting on participation in a WRAP program, an attendee shared:

> It gave me power to help myself, something that was never discussed with me ever as a mental health patient. And I operated the plan myself and I found it seeped into me. It's actually in my mind now, without me being consciously thinking about it. It's operating in my mind. I don't have to go back to the book. It's also changed my language; everything has changed in me in how I do things. (p. 192)

When looking at empowerment, Pratt, Macgregor, Reid, & Given, (2012) quoted a respondent on mental wellness:

> It's back at this key concept again essentially. It's like the self-responsibility…and I think it's awful easy-and this is me talking from my experience…it's awful easy to say, "Oh I have this dreadful illness," and, that's it. It's all hopelessness and despair. Aha. I have an illness, but by Jove I think there's more to life than that, and I've got to assume responsibility for my quality of life. (p. 404)

Summary

Based on the paucity of research studies specifically on mental wellness, it was safe to say there was a gap in analysis. Also it is relevant to note that many of studies were done in countries where some form of national health care was operational. More

studies are needed, not only to define mental wellness, but also to determine the best practices to promote and maintain it. Concept analysis was the primary method for determining an operational definition of mental wellness. Suggestions for further study include qualitative studies to develop the blueprint for mental wellness then quantitative studies to incorporate the bricks and mortar that support the concept of mental wellness.

Mental wellness needed to integrate the individuals coping skills, personal strengths, previous accomplishments, hopes, and dreams in the context of life and its circumstances (Wand, 2013). As with other current trends in health care, mental health and wellness needed to adopt a collaborative approach with the consumer to achieve the best results for all involved.

Chapter Three

Methodology

The methodology that was utilized for this study was concept analysis. By definition, concept analysis consisted of looking at concepts considered important to a discipline (nursing) with the intent of illuminating its distinguishing characteristics or attributes (Cronin & Coughlan, 2010). Historically there had been a consensus among nurses that concepts were the means by which communication occurs between individuals in a social milieu (Duncan, Cloutier, & Bailey, 2007). Walker and Avant (2011) have stated that the purpose of concept analysis was to dissect the structure and meaning of a concept. Weaver and Mitcham (2008) have elaborated on the definition and purpose by identifying it as a way to create and refine mental constructs. These mental abstractions or elements of significance were developed in relationship to the human experience. Concepts were therefore manifested through language and were not limited to science but also part of a natural human experience that took place in the context of community or being with others (Hupcey & Penrod, 2005). In contrast, Walker and Avant (2011) have recognized that concepts could not be defined by words because their reality lies in the mental image of a phenomenon related to an idea about a thing or an action. As a result, concepts were a mental experience and could not be adequately quantified in the context of language (Beckwith, Dickinson, & Kendall, 2008).

Concepts were sometimes referred to as the building blocks in theory (Risjord, 2009). The image of building blocks failed to capture the nonlinear paradigm of conceptual analysis. Hupcey and Penrod (2005) expounded on this by imagining knots

and a tapestry. They stated, “We assert that the power of concept analysis is to identify the existing theoretical strands that define a concept of interest and ultimately to tie and re-tie the conceptual knots to form a stronger, more coherent tapestry of theory” (p. 98). Based on this description, the concepts are tied together to keep the entire picture (theory) intact. From another aspect, concepts can be seen as the puzzle pieces and the completed puzzle results in the picture or theory.

Concept analysis helped to refine ambiguous concepts in the construct of a theory. It also facilitated clarification of terms that were common to the practice of nursing that may have been vague or overused so that subsequent uses of the term maintained a consistent operational definition (Walker & Avant, 2011).

Study Type/Design

For the purpose of this project, concept analysis as developed by Walker and Avant (2011) was employed to determine the concept of mental wellness. Walker and Avant identified eight steps to execute an appropriate concept analysis. The steps were:

1. Select a concept.
2. Determine the aims or purpose of analysis.
3. Identify all uses of the concept that you can discover.
4. Determine defining attributes.
5. Identify a model case.
6. Identify borderline, related, contrary, invented, and illegitimate cases.
7. Identify antecedents.
8. Define empirical referents.

Concept selection. When selecting a concept, it was important to avoid terms that were primitive and resulted in definitions through example only or umbrella terms that were too broad and multiple meanings that obscured the analysis (Walker & Avant, 2011). For the purpose of this study, the selected concept was mental wellness. As health care transitioned from a medical model to a wellness or health promotion model, it was imperative that the concept of mental wellness was appropriately defined from a basis of holism and humanness, rather than a disease process (Weaver & Mitcham, 2008).

Aim of analysis. The primary aim of this concept analysis is the development of a FBNMWC with an emphasis on mental wellness. Data collected and concepts identified were utilized to determine appropriate methods to promote and maintain mental wellness on an individual basis. It was essential to be able to differentiate among normal, everyday verbal usage of the concept of mental wellness and scientific usage of the same concept (Walker & Avant, 2011).

Identify uses of the concept. Through the use of dictionaries, thesauruses, colleagues, literature, cultural studies, arts, and entertainment, it was important to identify the many ways the term mental wellness was utilized. All uses of the term were reviewed and considered, including word origins. The aspects of physical, cultural, spiritual, and psychosocial dimensions of the mental wellness concept were also processed. Once processed, it was decided whether all aspects of the concept were considered or just those pertaining to scientific use were employed (Walker & Avant, 2011).

Determine the defining attributes. The defining attributes were the nuts and bolts or heart of the concept (Walker & Avant, 2011). Otherwise stated, they helped the

researcher and others to label manifestations of a specific concept that was distinguished from another to which it might have been similar or linked (Walker & Avant, 2011). Walker and Avant stated that the purpose was to find common characteristics which were critical to defining the attributes of a concept. Attributes were clustered to find those which were most frequently associated with the concept. In this study, the concept analysis data was utilized to cultivate a nursing model for developing and operating a FBNMWC with an emphasis on mental wellness.

Identify model cases. A model case was one that had all the defining attributes discovered in the analysis. A model case was an exemplar of absolute certainty in an occurrence of the concept (Walker & Avant, 2011). Model cases had been extrapolated from the literature, found in real life, or possibly constructed by the researcher. Model cases were developed through internal dialogue between what was familiar and the defining attributes that had been discovered about the concept. At this point, it was important to think out loud and discuss the analysis with other colleagues who were able to help hear things that the researcher could not hear with the internal dialogue (Walker & Avant, 2011). An example of a model case was someone who had a complete recovery from mental illness, as evidenced by the health care team determining the client was no longer in need of medication and professional therapy.

Identify additional cases. According to Walker & Avant (2011), identification of additional cases provided the opportunity to tease out either similar or contrary cases that helped solidify the actual defining attributes. Borderline cases contained part but not all of the attributes of the concept. Related cases were linked to the concept but did not contain all the defining attributes. Contrary cases were clearly not a part of the concept.

Invented cases were out of the experience of the one conducting the study. Illegitimate cases encompassed those situations where the concept was used improperly or out of context (Walker & Avant, 2011). A similar case was utilized when a client had demonstrated significant improvement but still required medication and/or professional therapy in order to maintain mental wellness. A contrary case was represented by a client who claimed to be mentally well but demonstrated behaviors consistent with mental illness.

Identify antecedents and consequences. Antecedents were events or actions that occurred prior to the concept occurring (Walker & Avant, 2011). An antecedent was not the event itself, but was present for the concept to be experienced, similar to a trigger. Antecedents, according to Walker and Avant, were helpful for identification of underlying assumptions related to the concept being studied. Consequences were the result of the conceptual occurrence or the outcome of the concept. A defining attribute could not be both an antecedent and a consequence (Walker & Avant, 2011). Antecedents to mental wellness would be the fruits of the Spirit, including love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self-control (Galatians 5:22-23, NKJV). The lack of these fruits resulted in the consequence of a decrease in mental wellness.

Empirical referents. Formulating the empirical referents for the defining attributes was the concluding step in a concept analysis (Walker & Avant, 2011). According to Walker and Avant, empirical referents were groups or divisions of real phenomena that, by their existence or presence, validated that the concept existed. These were not tools to measure the concept, but a way that identified and measured the

defining characteristics or attributes themselves. Empirical referents were directly linked to the concept but did not qualify as the complete concept. Manifestations that were associated with mental wellness were positive attitude, speaking the truth in love, and honoring others as examples.

Process. The process for concept analysis differed greatly from most research in that it did not always involve interaction with subjects, but was dependent on studies and sources that were already complete. The process involved sampling the literature and then writing down the characteristics. It was followed by the presentation of the model and exceptional cases that were not necessarily drawn from the actual data of the literature (Weaver & Mitcham, 2008). For the purpose of this study, databases using CINAHL with full text, Medline, ProQuest, PsychINFO, PsychArticles, ERIC, Religion and Philosophy Collection, and Google search were accessed. This method was known as theoretical concept analysis.

Advantages and limitations. Risjord (2009) wrote that the foundation for concept analysis was the presupposition that the substance of the concept was closely identified to the meaning of the word used to describe the concept. Therefore, when a person preferred one word over another to describe the context of their concept, that individual was recognizing that alternative terms failed to describe the concept or situation adequately. The intent of concept analysis was to clarify the symbols (words and terms) used when communicating (Walker & Avant, 2011). Clarification of mental wellness helped providers define the term from the perspective of the individual rather than what was perceived by the provider.

Additionally, through concept analysis terms and their actual meaning were

refined to restore true meaning rather than what was assumed. By identifying true meaning about concepts, healthcare updated and developed appropriate communication skills when relating to colleagues and patients (Walker & Avant, 2011).

Limitation of the study was the questioning of its validity due to a lack of quantification of data. The hope was that the result of the identification of concepts related to mental wellness provided a springboard for further research, both quantitative and qualitative. All research starts with a concept.

Budget. Due to the nature of this study, the amount of funds required was relatively small. Expenses included the purchase of research articles, movies and documentaries, and fuel to visit local wellness centers. At the time, there were no other perceived expenses, but a budget of $500.00 had been assigned to cover the cost of the project as proposed by the researcher. A suggested budget can be found in appendix B.

Summary

With current trends in health care ascribing to a wellness model, it was important to define the concept of mental wellness. Because concepts were defined as phenomena of experience, it was important to determine the experience as perceived by those with the experience and those observing the experience. Concept analysis provided data to help find words to describe the experience and thereby greater understanding of what the patient was experiencing. As the concept of mental wellness became defined, more research and theory needed to be established. Ultimately the data helped support the formulation of a healthcare model (as seen in Appendix D) that can be instrumental in the development of faith-based, nurse-managed wellness centers.

Chapter Four: Results

Concept Analysis: Mental Wellness

The purpose of this analysis was to determine an appropriate definition of mental wellness for the purpose of developing a model for a faith-based nurse managed wellness center with an emphasis on mental wellness. This process was accomplished by utilizing the method identified by Walker and Avant in *Strategies for Theory Construction in Nursing (*2011). This process helped to determine an operational definition of mental wellness rather than an assumed one.

Selection of concept. As stated in previous chapters, the concept of mental wellness was explored in this paper. Although the concept of wellness had been present seemingly forever, the coupling of it with the word mental was not frequently encountered in scientific reading. Mental was more commonly paired with the word illness or health rather than wellness and implied a deficit rather than asset. Wellness was often limited to the word well and usually attached to the word being.

Aim of analysis. The intent of this paper was to clarify and analyze the concept of "mental wellness" in an effort to develop an operational, clear understanding of the term especially as it related to the profession of nursing. The purpose of concept analysis was to derive a meaning based on the defining attributes of a concept that establishes a functional definition rather than a dictionary definition (Rodgers, 1989). The analysis as stated earlier was processed through the framework described and utilized by Walker and Avant (2011). Through this concept analysis was the hope that mental wellness would be addressed in the full context of wellness.

Uses of the concept. The actual concept of *mental wellness* was addressed through the two separate words of *mental* and *wellness.* A combination of the two was virtually nonexistent in dictionaries, thesauruses, and similar publications. Based on a literature review, the first concept discussed was *mental* followed by the word *wellness.* The following list of definitions is grouped categorically:

- General: The Oxford English dictionary (OED, 2013) defined mental as (1) senses relating to the human mind (2) carried on and performed by the mind; taking place in the mind; formed in the mind (3) relating to the mind as a field of study; concerned with phenomena of the mind, (4) characterized by the possession of an active mind; thoughtful; intellectual, (5) senses relating to the mind in an unhealthy or abnormal state (designating a temporary or permanent impairment of the mind due to inherited defect, injury, illness, or environment, usually needing special care or rehabilitation or designating a person specializing in the treatment or care of individuals with disorders of the mind, a person suffering from an illness or impairment of the mind (6) mentally ill; mentally handicapped. Also in a weakened sense: irrational, uncontrolled, eccentric, crazy. Dictionary.com (2013) further described mental by adding the provision of care for persons with disorderly minds: pertaining to intellectuals or intellectual activity. The noun included an informal definition as a person with a psychological disorder (Dictionary.com, 2013).
- Biology: of or relating to the chin (Dictionary.com, 2013)

- Mental in Medicine: of or related to the mind or affected by a disorder of the mind; intended for treatment of people affected with disorders of the mind (Dictionary.com, 2013)
- Taber's Cyclopedic Medical (2013) defined mental as relating to the mind or relating to the chin. Wellness was good health, as well as appreciation and enjoyment (Taber's, 2013). Wellness is more than a lack of disease symptoms; it is a state of mental and physical balance and fitness.
- The OED described wellness as (1) the state or condition of being well or in good health, in contrast to being ill; the absence of sickness; the state of (full or temporary) recovery from illness or injury. The U.S. definition elaborated on wellness as a positive rather than contrastive quality; the state or condition of being in good physical, mental, and spiritual health, especially as an actively pursued goal; well-being.
- El-Rayes in his book "Mental Wellness a Spiritual Journey" (2011), described mental health as a stationary way of existence, implying either mentally ill or mentally well, whereas mental wellness as an active life- long process related to making choices to allow individuals to obtain their potential and live life to its fullest. It is an intentional effort to pursue spiritual growth, life purpose, and self-actualization (El-Rayes, 2011, pp. 24).
- The Hebrew word shalom was used by the Israelites to describe wholeness or wellness and was defined by Benner (n. d.) as a verb meaning to "restore through provision or replacement to make one whole or complete". The noun identifies

shalom as the person who has received the necessary provision of what was needed to allow them to be whole or complete in spirit, soul, and body.

- The word *nephesh* in Hebrew is problematic to translate into one English word. The most frequent definitions included “person,” “soul,” ‘life,’’ or “mind”. In this context, it related not only to the carnality of being human, but it also incorporated the spiritual existence of being human (Renn, 2005).
- The Greek usage of the word mind involved the terms *dianoia,* and referred to the seat of human emotion, reasoning, and understanding; *nous* the volition, moral and cognitive function of the mind; and *phronema* carried the connotation of the mind being the volitional and rational center or the spiritual mind (Renn, 2005).

In reviewing these definitions, it was not difficult to recognize many of the negative inferences associated with the term *mental.*

Defining attributes. Defining attributes were identifying characteristics that provided a genuine and practical definition in contrast to one found in the dictionary (Rodgers & Knalf, 2000). Five defining attributes were derived for the concept of mental wellness as it related to the development of faith-based nurse managed wellness centers with an emphasis on mental wellness.

- People consist of spirit, soul, and body and are identified as triune beings.
- Spirit consists of that which is supernatural: that which is above or beyond natural law: otherworldly, breath of life (Hayford, 1995). Smith and Robinson (2015) define spirituality as the meaning of life as connected through relationships and values.

- Soul contains the mind, will, emotions, reason and understanding of an individual human being. It is also identified as personality (Hayford, 1995).
- Body incorporates the physical and physiological existence of an individual including the senses, well-being, that which may be afflicted, and appearance (Hayford, 1995. pp. 764).
- The relationship between spirit, soul, and body strongly influences mental wellness.

Model case. Nancy is a 45-year-old registered nurse who recently strained her back while working. Realizing that wellness had not been her health paradigm, she decided to change her focus to a health promotion nursing model from a disease centered medical model. She made an appointment at the Neighborhood Clinic, a faith-based nurse managed clinic that incorporated mental wellness as an integral part of overall wellness. Upon her arrival to the clinic, a warm and friendly front office person who explained the philosophy of the clinic to Nancy greeted her. She shared with Nancy the importance of having the right mind set to maintain overall health and that part of her intake assessment included mental and spiritual wellness as part of her "health" assessment in addition to the traditional health intake form. (See appendix A).

While Nancy was filling out the required information, she noticed a large-screen television in the back ground playing a live cooking show currently being taught in another location at the clinic. As she glanced around the facility, she noticed a large playroom with several supervised children playing together in a safe and monitored environment staffed by early and elementary education students. The laughing and giggling of the children made Nancy smile. After she returned the necessary forms to the

front office, a student nurse escorted Nancy back to an assessment room. The student nurse then proceeded to do a complete health history and physical exam which incorporated open-ended questions under the supervision of the nursing instructor. Once the physical component of the exam was completed and the nurse exited the room, a master's student from the psychology department entered to interview Nancy from information Nancy shared in the Personal Health Questionnaire (PHQ-9, See appendix A). After sufficient time with the psychology student, Nancy was visited by a theology major who introduced her to Sozo© (inner healing) opportunity to examine her relationship with God, especially as it related to her overall health status.

The counseling center incorporated spiritual and mental wellness along with diet and exercise components, established from motivational interviewing between the counselor and Nancy. Once the assessment was completed, Nancy met with the team to discuss her wellness goals. Nancy and the team developed a comprehensive wellness plan with a focus on mental wellness. Items addressed in the wellness plan were a realistic eating program, stretching exercises for her back, an appropriate aerobic program, Bible study references and recommended faith-based books. Nancy was also given a schedule of services offered at the clinic including an organic cooking class, yoga, Bible studies, aerobics, stress management, personal boundary setting, Celebrate Recovery® (faith-based 12 step program), Sozo© (inner healing), and a gathering place to share a cup of coffee and talk. As Nancy prepared to leave the clinic, she was given a follow-up appointment and assured that she could come by or contact the facility at any time she felt the need. She was also assured that someone from the staff would make contact with her to find out how she was doing at least once a week until her next

appointment. Prior to leaving, Nancy was asked to fill out the 9 item Shares Decision Making Questionnaire (SDM-9, see Appendix C) to contribute to the clinical staff's outcomes related to patient care and satisfaction.

Analysis. Through this model, Nancy's assessment included spirit, soul, and body as the basis for wellness. Other contributing factors to pain, such as psychological or spiritual needs, were addressed. Appropriate practitioners were utilized for each area of Nancy's personhood through those practicing nursing, psychology, and vocational ministry. As a result, all areas important to Nancy's wellness were addressed and a collaborative wellness action plan was developed between practitioners and Nancy.

Identification of additional cases.

Borderline case. Nancy presented to the Neighborhood Clinic with back pain and was interested in trying some alternative methods for healing because she could not work while consuming pain medication. After an intensive intake consisting of a physical, mental, and spiritual health history and physical, the student nurse and instructor addressed concerns with Nancy and helped her to develop a plan of care to meet her desired outcomes. The nurse practitioner wrote a prescription for gabapentin to help control the pain and encouraged Nancy to take the narcotics at night and on her days off until the pain was controlled with acetaminophen or ibuprofen. The missing construct in this particular case was the absence of a multidisciplinary, integrated approach. Although all constructs were addressed, experts were not utilized to address areas of psychological and spiritual concerns (soul and spirit).

Related case. The providers at the Neighborhood Clinic saw Nancy for low back pain. After filling out the necessary paperwork, she was seen by the student nurse and

the faculty clinical instructor. The student, under faculty supervision, completed a comprehensive history and physical. After the student nurse finished, a psychology student, also under faculty supervision, assessed Nancy for any psychological distress that may have been contributing to her low back pain. The student nurse and the psychology student met with Nancy to develop a plan of care with her. What was absent in this scenario is addressing the spiritual attribute of wellness.

Contrary case. Nancy visited the Neighborhood Clinic with complaints of low back pain. She requested to see a physician to obtain a prescription for pain medication and a muscle relaxant for her discomfort. Because the clinic was a nurse-managed wellness center, none of the personnel had prescriptive authority. Nancy was referred to an urgent care center specializing in occupational medicine to meet her pain needs because of the need for medication to help alleviate symptoms. She rated her pain as an 8 out of 10 and was unable to identify any alleviating factors other than pain medication at this time. The constructs missing in this case were related to Nancy's need for non-nursing interventions and not being ready to address psychological and spiritual issues that may have been related to her pain due to the intensity of her pain.

Invented case. An alien life form landed in New York City right after the 9/11 incident. This alien picked up on the stress, angst, and pain of the environment immediately. She was able to separate herself into three different life forms, manifesting in her physical being (body), her thoughts (soul), and her spiritual self. All three parts dialogued together to assess how she was doing and to evaluate her response to the situation. She observed that her body experienced an increased heart rate, along with pain in her stomach; her soul felt angst and deep sorrow; her spirit was grieved, but felt

sorrow also for the perpetrators as well as the survivors and the lost; she knew this was not God's will for any living being. By connecting with all three parts of her being, she acknowledged what was happening to her; she addressed each separately and in the context of the whole. She knew that if anything became out of alignment, it would affect her wellness, leading her to develop resources for care if things started to become chaotic. Although she presented as one being, she recognized that the three parts of her made the whole and well. This case demonstrated addressing all three parts of being in order to obtain mental wellness.

Illegitimate case. Nancy reported to her provider that she was at the clinic for a mental wellness assessment. The provider proceeded to assess Nancy by inspecting and palpating her chin based on the biological definition of mental. This was an example of the term being used improperly in the context of mental wellness.

Antecedents and Consequences

Antecedents are what occur prior to the concept.

Antecedents.

1. Health care environment
2. Wellness/disease continuum
3. Ability to make decisions
4. Personal identity
5. Level of autonomy
6. Holistic
7. Trusting relationships
8. Healthy thought life

Consequences.

1. Mental wellness
2. Control of negative or toxic thoughts
3. Increased self-esteem and confidence
4. Identification of why plan fails
5. Nurture autonomy
6. Recognition and intervention of triggers
7. Revelation of truth

Empirical Referents

Empirical referents are exhibited through how the concept was measured or how this phenomenon was identified in reality.

1. Quantifiable measures of mental wellness
    a. Self-reported increased happiness or hedonia
    b. Self-reported decrease in pain (spirit, soul, and body)
    c. Self-reported improvement in relationships
    d. Decreased score on the Patient Health Questionare-9 (See Appendix B)
    e. Decreased number of absenteeism and presenteeism due to pain
    f. Improved quality of life.
    g. Recognized and thwarted ANTS
    h. Regular periods of fun events
2. Collaboration between patient and health care team for developed plan of care
    a. Patient adherence to plan of care

b. Follow-up appointment to determine effectiveness of plan of care with patient and healthcare team
c. Weekly follow-up phone contacts with patient to provide encouragement and nurturing
d. Verbalization by patient of how adherence to the plan of care was established and maintained
e. Utilization of therapeutic communication and motivational interviewing by the health care team

3. Problems identified in the context of the plan of care
    a. By the patient
    b. By the health care team
    c. By collaboration between the patient and health care team
    d. Through trial and error
    e. What worked and what did not work
    f. Evaluation of care by the 9-Item Shared Decision Making Questionnaire (SDM-Q-9) (See Appendix C)

Conclusion

In the simplest of terms, research means to look again. This was precisely what a concept analysis did: to look again for a hidden or deeper meaning of a concept. In the case of mental wellness, the actual concept was not well defined by science. Although the terms mental and wellness were present in the literature and a plethora of definitions existed for each word, the marriage of these two concepts was elusive in the current

literature. The term mental related to the mind and thoughts. Wellness went beyond the absence of illness but tended to embrace the totality of an individual or community.

Thoughts are an integral element of mental wellness. Many people struggle with automatic negative thoughts (ANTS) that can lead to decreased mental wellness through low self-esteem, auditory hallucinations, depression, and anxiety (Amen , 2002). Leaf (2009) refers to these brain games as toxic thoughts. Scientists were more than familiar with what toxicity did to the body through medications, exposure, and recreational drugs, to name but a few. But what effect did toxic thoughts have not only on mental wellness, but physical and spiritual wellness? This was the purpose of the concept analysis of mental wellness. What was mental wellness? What did it look like? How was it achieved and maintained? What role did nursing play in this along with other disciplines such as psychology, theology, and education?

Operational definition. In assessing the terms mental and wellness, common themes arose. The word, mental, was primarily related to the function of the brain. The brain exhibited mental activity, thoughts, patterns of thought, and intelligence. Wellness was traditionally surrounded in contrast to illness. It appeared that wellness was only definable by the absence of symptoms that related to illness. The problem with wellness in this context was the elimination of the possibility of being ill and well at the same time. For example a person who was dying could be healthy mentally by understanding that the physical body was terminal, but the soul and spirit were eternal and were at peace with the finality of physical existence and embraced the journey of life and death.

Mental wellness as an operational definition was the sum of spirit, soul, and body, working in harmony as it was influenced by relationships, community, thoughts, intellect,

and environment (see appendix D). A FBNWMC would help the client to identify the source of the problem. This consists of determining if the pain was indeed physiological, mental, or spiritual or a combination of any or all three. Confronting the automatic negative thoughts with the truth allows the nurse to facilitate her client toward personal continual growth to reach individual maximal personhood. In this context, it is critical that individuals identified the emotion they may have experienced and why that emotion surfaced at that particular point in time. Once the reason has been identified the people were free to determine how to deal with the feeling and determine how to move forward without getting stuck in that moment.

Model.

Nursing curriculum implementation. Current nursing curriculum has addressed mental illness and touched on mental wellness through courses such as mental and community health nursing and health promotion. Most nursing curriculum found its home in illness recovery rather than maintaining or improving wellness especially outside

of the acute care situation, or the medical model. Implementing mental wellness into nursing curriculum could be done with a few minor tweaks to make it adaptable.

Perhaps the most comprehensive way to address mental wellness in nursing curriculum is to weave it throughout the curriculum. Any hospitalized patient is vulnerable to declining mental wellness due to an altered physical condition, change in routine, stress (especially as it relates to the unknown), or a generalized loss of control amongst other deteriorating conditions. Asking simple questions such as "What would it take to make you healthy?" or applying skills of active listening could be incorporated into the patient's plan of care. Simulation or role-playing case studies regarding mental wellness can also applied. The concept of thought detoxification (Leaf, 2009) over the semester, engaging the students through journaling, also can prove to be effective. It would be relatively effortless for students to point out to a peer when they were expressing toxic thoughts. Community and mental health settings are also areas where a mental wellness paradigm could easily be executed.

Because clinical sites are a precious commodity in nursing education, the implementation of a FBNMWC would not only help the learning institution, but also the community at large. The emphasis on wellness implies more teaching and support rather than acute intervention by nurses. Students would be utilized to provide patient care under the supervision of advanced practice clinical faculty. Students who participated in mental health, community health, health promotion, complementary alternative methods, or elective classes easily provide the necessary care.

Mental wellness incorporated into nursing curriculum provides a holistic approach to nursing care. In addition, it offers an opportunity to practice for the

transition of acute care to wellness. Not only do the patients benefit, but the students also have an opportunity to study their own wellness behavior and hopefully model it to others.

Resources: Ethical, Legal, Financial, and Organizational

In 1974 the United States government passed the National Research Act that provided standards to protect human subjects in the arena of biomedical and behavioral studies (CDC 2013). As a result, it required that voluntary and informed consent needed to be obtained from the subjects who participated in research. Ten rights of participants in a research study were also developed for participant protection (Terry, 2012). Because human subjects were not involved in this project, no consent was required nor was the rights needed to fulfill task. In addition, all information utilized was previously published work available to the general public.

Although ethics and morality were often used interchangeably, there is a subtle difference. In a somewhat simplified definition, Rae (2009) defined morality as knowledge of right and wrong and ethics is the process of determining why something is right or wrong. While no human subjects were included in this conceptual analysis, the ethical standard driving it was beneficence. Beneficence outcomes were to provide maximum benefit and prevent damage (Polit & Beck, 2014). The purpose of this concept analysis was to provide a definition of mental wellness to prevent harm and provide benefit or good.

Financial resources for this project were minimal. Most of the resources reviewed were provided through library and online services. Attached as appendix B is a budget that entails perceived start-up costs for the establishment and function of a FBNMWC.

Clinical facilities for a school of nursing are a precious commodity due to competition for different schools. One of the reasons for establishing a FBNMWC would be to provide optimal clinical experience for registered nursing students. As a result, the organizational praxis would be achieved under the auspices of Simpson University. The clinic falls under the structure and bylaws of the university.

Limitations

Concept analysis is unique in that it does not require subjects to interview or numbers to be quantified. The concepts were related to the use of language study through resource books, literature, the arts, entertainment and culture. Wilson's Thinking with Concepts (as cited by Walker & Avant, 2011) identified seven potential limitations with the use of concept analysis:

1. Value implications of a concept that can lead to bias
2. Feeling of being overwhelmed because of a lack of a concrete approach
3. The feeling that it is too easy which results in impatience and assuming that everyone "already knows this"
4. Not knowing when to quit
5. Protecting oneself from criticism rather than embracing and learning from it
6. Substituting verbiage for substance
7. Adding unnecessary defining attributes

The end product of concept analysis is actually only a beginning because the results are always tentative and intended to be further developed.

Summary

Mental wellness extended beyond the concept of mental health, which tended to be associated with illness as opposed to health. The operational definition of mental wellness arrived at by formal concept analysis was the sum of spirit, soul, and body, working in harmony as it was influenced by relationships, community, thoughts, intellect, and environment. Mental wellness was another tool to place in the health toolbox that promoted shalom, wholeness, and longevity. The operational definition can be used to conceptualize a FBNMWC. Specific goals of the wellness clinic included the potential population served, the services to be provided, the inclusion of students from various disciplines to bring comprehensive care to the clinic's patients while obtaining clinical practicum hours. Through the abolition of negative thinking, and the addition of positive relationships, physical fitness, and knowing truth, perhaps a person can truly become self-actualized. Nurses along with an integrated health care team can champion this cause and transform health care in the United States in the proposed FBNMWC model. As a result, it is expected that rates of depression, anxiety, and other mental illness would be decreased along with health care costs.

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Appendix A

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Appendix B

Budget Proposal
A Faith Based Nurse Managed Wellness Center with an Emphasis on Mental Wellness

PI: R Swartzman, DNPc

Estimated total budget to complete the research $ 32,800

Explanation of major budget items:

Personnel:			
PI Professor Swartzman	25% effort	Salary funded by the University	0
Adjunct faculty x 5	100% effort	Salary funded by the University	0
Undergraduate RN students			0
Facilities:			
Office space donated by SDA Church or the University			0
Utilities	$1,000 per semester (3)		$3,000
Durable Medical Equipment and Supplies:			
Blood glucose monitor and equipment			$5,000
Multi styx urine dip sticks	$ 250.00 per month		$3,000
Vital signs Machine (2)			$4,000
Used exam table (1)			$500
Office furniture (donated by the University)		0	
Other Equipment & Supplies			
Computers, ipads, and software (pt education and documentation)			$10,000
Computer thumb Drives (100 @ $5.00 for patient to have copy of MR)		$500	
Apple TV			$100
60 inch plasma TV (1)			$1,200
Marketing supplies for web page, printed material			$2,500
Travel:			
Airline tickets and lodging to Memphis to observe clinic (3)			$3,000
Total cost			**$32,800**

Appendix C SDM-Q-9

The 9-item Shared Decision Making Questionnaire (SDM-Q-9)

[Example] **Please indicate which health complaint/problem/illness the consultation was about:**

[Example] **Please indicate which decision was made:**

Nine statements related to the decision-making in your consultation are listed below. For each statement please indicate how much you agree or disagree.

1.	**My doctor made clear that a decision needs to be made.**					
	completely disagree ❑	strongly disagree ❑	somewhat disagree ❑	somewhat agree ❑	strongly agree ❑	completely agree ❑
2.	**My doctor wanted to know exactly how I want to be involved in making the decision.**					
	completely disagree ❑	strongly disagree ❑	somewhat disagree ❑	somewhat agree ❑	strongly agree ❑	completely agree ❑
3.	**My doctor told me that there are different options for treating my medical condition.**					
	completely disagree ❑	strongly disagree ❑	somewhat disagree ❑	somewhat agree ❑	strongly agree ❑	completely agree ❑
4.	**My doctor precisely explained the advantages and disadvantages of the treatment options.**					
	completely disagree ❑	strongly disagree ❑	somewhat disagree ❑	somewhat agree ❑	strongly agree ❑	completely agree ❑
5.	**My doctor helped me understand all the information.**					
	completely disagree ❑	strongly disagree ❑	somewhat disagree ❑	somewhat agree ❑	strongly agree ❑	completely agree ❑
6.	**My doctor asked me which treatment option I prefer.**					
	completely disagree ❑	strongly disagree ❑	somewhat disagree ❑	somewhat agree ❑	strongly agree ❑	completely agree ❑
7.	**My doctor and I thoroughly weighed the different treatment options.**					
	completely disagree ❑	strongly disagree ❑	somewhat disagree ❑	somewhat agree ❑	strongly agree ❑	completely agree ❑
8.	**My doctor and I selected a treatment option together.**					
	completely disagree ❑	strongly disagree ❑	somewhat disagree ❑	somewhat agree ❑	strongly agree ❑	completely agree ❑
9.	**My doctor and I reached an agreement on how to proceed.**					
	completely disagree ❑	strongly disagree ❑	somewhat disagree ❑	somewhat agree ❑	strongly agree ❑	completely agree ❑

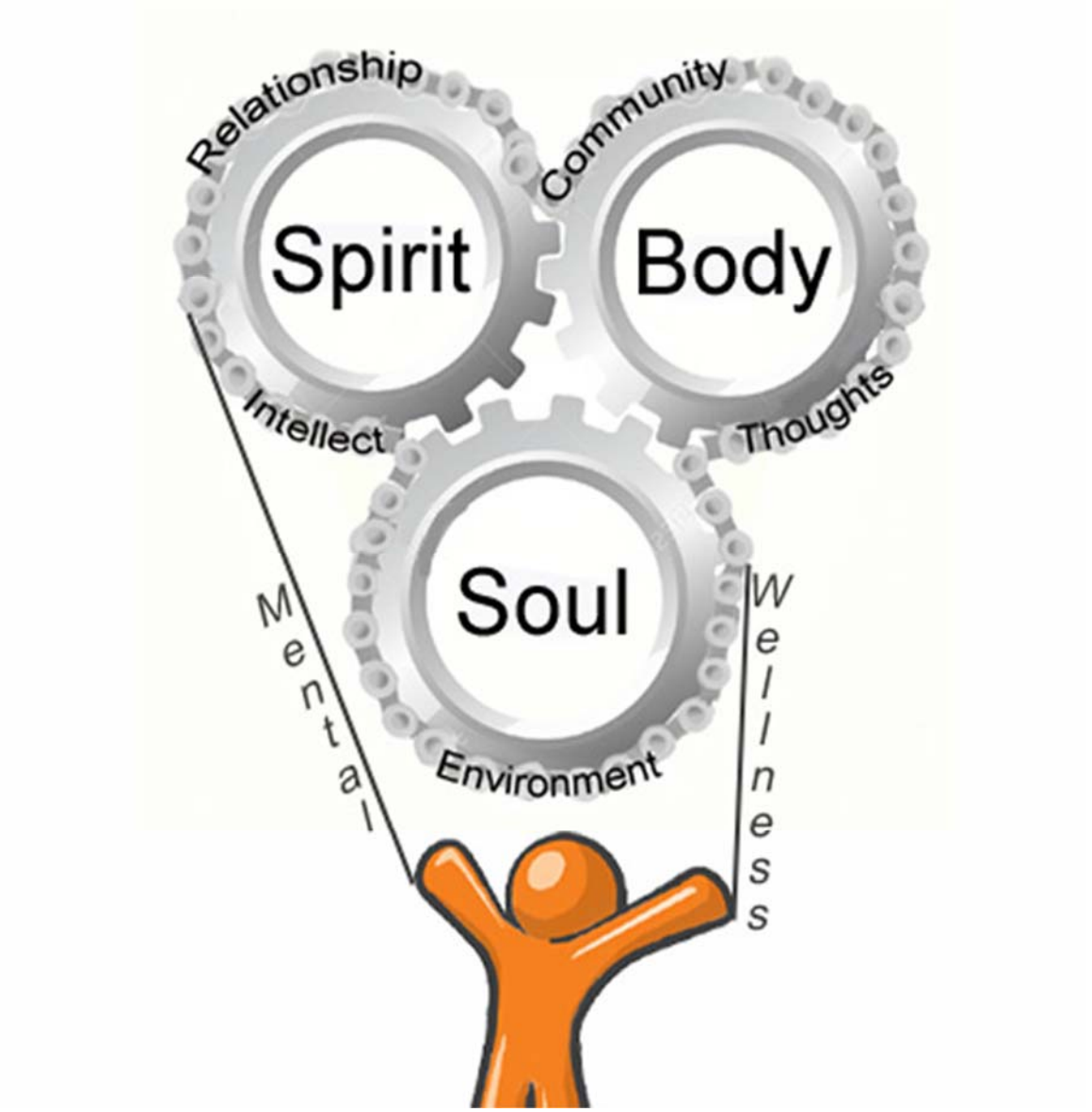
Relationship
Community
Spirit
Body
Intellect
Thoughts
Soul
Environment
Mental
Wellness

Table 1: Summary of Investigations of Mental Wellness Studies

Author and Location		Study purpose	Method/sample	Major findings
Bluthenthal et al. (2006); USA		Developing mental wellness awareness related to depression in individuals and communities	Qualitative : Self-administered questionnaire, field notes, and qualitative interviews N= 63	Depression described as an individual and community problem. Needed intervention was talk to de-mystify depression, build community strength and services, and support through policy and advocacy for vulnerable populations
Cook et al. (2010); USA		Self-management of mental illness taught by peers to people in mental health recovery using a Wellness Recovery Action Plan.	Qualitative: anonymous written feedback N=381 Quantitative: pre-, post-test, utilizing two-tailed *t*-test	Wellness was obtainable, as was growth in support networks, new knowledge and skills for mental wellness Quantitative results significant with $p<0.05$
Higgins et al. (2012); Ireland		Evaluation of Wellness Recovery Action Plan	Qualitative: focus groups Quantitative: questionnaires, paired sample *t*-test N=67	Life plan as opposed to an illness recovery plan; empowerment, increased self-belief and capacity for wellness and recovery. Quantitative: improved knowledge and attitudes between pre- and post-test with $p<0.0001$
Keogh et al. (2014) Ireland		Effectiveness of a mental health Wellness Recovery Action Plan education	Qualitative: focus group post educational program using semi-structure interview	Enhancing knowledge and skills r/t WRAP, facilitation of WRAP, empowerment r/t WRAP
Marchinko and Clark (2011); Canada	Utilization of mental health wellness planner	Qualitative: Semi-structured interviews N=42	Empowerment, self-advocacy	
Pratt, MacGregor, Reid, and Given (2012); Scotland	Assess relevance and impact of WRAP in group settings, as a tool for self-management and wellness	Qualitative: focus group and facilitator interviews N=8	Mutuality, on-going process, personal responsibility for wellness	

Russell and Browne (2005); Australia	Effectiveness of stay well plan with persons diagnosed with bipolar disorder	Qualitative: written by participant or collected through personal interview N=100	What staying well meant, Acceptance of diagnosis, being mindful of having bipolar disorder, being educated about bipolar disorder, identified and addressed triggers, recognized warning signs of decompensating, management of sleep and stress, alternative treatments, access support, importance of having a stay-well plan
Valadez, Lumadue, Gutierrez, and de Vries-Kell (2006) USA	The effects of Adult day care centers on the emotional state of elderly Hispanic women	Qualitative: semi-structured that mirrored everyday conversations N=24	The adult day care center provided activities, socialization, spiritual, support, in a cultural context resulting in decreased reports of loneliness and depression