THE RECIPROCAL RELATIONSHIP OF SELF AND PRACTITIONER: A NARRATIVE INQUIRY SELF-STUDY

by

Christina Di Stasi, BScN, 2011

Ryerson University, Toronto, Ontario, Canada

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ABSTRACT

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In an increasingly demanding environment like healthcare, nurses may often be meeting their professional responsibilities at the expense of their personal needs. Existing research shows the benefits of engaging in experiential learning, such as reflective practices. By using reflective practices, nurses can reveal challenges in the workplace that affect their professional performance, opening discussion for how these could be mitigated. By engaging in a self-study, using Connelly and Clandinin's Narrative Inquiry, I explore the mutually informing nature of personal and professional formation. I tell personal stories of my childhood and professional stories of my time as a nursing student, new graduate and current practitioner. Using the analytical framework of Narrative Inquiry, I identify two narrative patterns (*vulnerability* and *belonging*) in my lived and told stories. I highlight how social interactions influence our personal and professional identities, and how this understanding offers development opportunities to benefit the nurse-client relationship and society.

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DEDICATION

I would like to dedicate this thesis to my parents, who both raised me with love, despite their differences.

To my dad, who persisted to give me the best in life, holding me close in his heart despite our physical separation. I am grateful to always be your *little girl*.

To my mom, I am blessed by your devotion to me. Thank you for always working hard for our family, teaching me how to be strong, independent, and resourceful. Despite any consequences, who I am today is because of you, and I am proud.

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PROLOGUE

In grade two, with my parent's divorce, my life turns off a paved road onto a gravel trail with illegible signposts. I fixate on the new constants of moving day: the layout of my new home, the first car ride with my mom and my brother to "have a look around the neighborhood", and my plastic pink child's vanity table, glowing in the sunlight through the blinds of the room at the top of the stairs. I read a book hiding behind a small bookshelf, not yet pushed flush against the wall, listening to the unfiltered conversation of the movers as they set up the box spring and mattress of my mother's bed. I am curious more than anything – fearless in the way only a child can be with a naivety for consequences.

A small playground is steps away from the front door of our new townhouse, in the middle of the common ground between the connecting buildings encircling the neighborhood apartment building. In the midst of all the movement around me, I venture outside to explore the wooden structure, running up the slated ramp, and sliding down the plastic half-pipe onto the soft sand below. After a time, a girl older than myself joins me in the park area, climbing, running and sliding on her own. We revolve separately for a while around the wooden structure, until finally meeting together at the top where we remain in silence. For moments we stand apart from one another until finally I look up and our eyes meet.

"You don't belong here" She says.

* * *

I've found there are few things as terrifying as finding yourself in a situation in which you feel helpless, and this is magnified when that situation involves life and death.

As a novice nurse in training, I'm walking down the halls of a busy medical-surgical unit on the third shift of my new clinical placement, during my second year of university. I'm on the

way to check on my patient but am stopped in my tracks by a sudden shout of alarm and the tail end of a sentence:

"…on the floor!"

A rumble of footsteps shakes the floor from my right as I see a crowd of people, previously scattered around the nearby nursing station, gather together and funnel into a patient room just ahead and to my left. Without thinking, I blindly follow the herd into the room and see a nurse kneeling on the floor hunched over an older man's body. As her arms drive down his chest to perform compressions, she calls over her shoulder:

"…Code Blue!"

It seemed like a matter of seconds as I stood there, looking at the scene in front of me. The naked barrel chest of a man is replaced in my vision by the blue-vested half-torso of a mannequin used in my CPR certifications classes. There is no black circle in the middle of the chest to mark the placement of your hands, nor the flat back of the head to make it lay steadily on the floor as you performed the "head-tilt chin-lift" to open the airway. Instead there is a dying man on the ground, surrounded by nurses and other health care professionals working with an impossibly calm flourish.

As members of the greater unit, they steer a crash cart into the room, apply oxygen, cycle through compressions, start an intravenous line to inject medications, and prepare to deliver an electric shock. Everyone has a role to play it seems, in trying to bring this man back to life. And yet, all I can do is stand here – helpless, unprepared, and vacant.

All I can think of is,

"Do I belong here?"

* * *

As a member of the nursing float team at the hospital I'm working in, I am expected to go wherever they need me. Orientation is given for each unit, albeit sparingly, yet I am grateful for some of the ones I have little experience with. As far as the remaining units I travel to, because this is my second attempt working in an acute care hospital, I'm glad I have my five years of previous working experience to rely on.

The one unit I can't stand working in is the emergency room. Despite the specialized skills required to work in the acute and subacute zones, float nurses like myself are often needed in the step-down area. This step-down is still considered part of the emergency unit, and anything can happen with these "stable" patients as they wait for tests, specialists, or a bed up on the inpatient units. This place is a natural disaster. Everything from the scattered papers, the cramped spaces, and the cries of distress give me anxiety. I try to be everywhere and end up being nowhere; struggling to keep my head above water in these crashing waves of orders, tests, and velocity.

On this particular day on the step-down unit, it isn't long before I crash. This time, I'm trying to explain to a morbidly obese man why he was prescribed a particular IV antibiotic for his osteomyelitis, and he is telling me: "It won't work". He has been to the hospital many times in the past (what health professionals refer to as a "frequent flyer") for the same issue, often signing himself out 'against medical advice' before treatment can be completed.

I feel my breath catch in my throat, and my voice starts to waver as I'm thinking of all the other things I need to accomplish: charting, finishing my medication rounds, and hopefully stepping away to eat something as I've missed my morning break. Thankfully, one of the other nurses notices and steps in as tears begin to form in the corner of my eyes. This is the charge nurse and she asks if I have gone for break. I shake my head and start to protest, as I have other

tasks I need to finish, but she puts her hand on my back and says:

"Go for break, we will cover you", referring to the other nurses I'm working with today. I look up to see their faces fixed on mine - curiosity and pity- a silent acknowledgment that they have been where I am.

As I walk to the entrance of the unit, the charge nurse is following close behind, and before we part ways she says one last thing that refuses to leave my mind:

"Don't worry about your patients. They aren't going to worry about you".

Her kindness is overshadowed by my feelings of truth in that statement, but also the hypocrisy of my actions. I DO worry about my patients, and yet I worry about myself. Perhaps it isn't just a question of where I belong, but ultimately of what drives me: who am I, and who do I want to be?

CHAPTER ONE

Introduction

The profession of nursing continues to evolve, and as such, individual practitioners are urged to grow with it. My journey takes place along a winding path that began prior to my decision to even pursue the profession. In my youth, I believed I wanted to pursue teaching, so I set a course for myself that would lead me towards this goal. Driven by a feeling, without any real explanation as to why I thought it was the right choice for me, I actively sought opportunities in education, and volunteered my time to increase my chances for admission into a highly competitive teaching program.

The particular program I desired required me to be a student for a year at my chosen university, before applying to the teaching program in the second year. While waiting to apply, I sought relevant experience in education and volunteering that would improve my chances of selection. As I worked through after-school mentoring programs, and conflict resolution workshops for curriculum development, I made a terrifying discovery: I did not care for any of it. Despite this realization, I still chose to apply for the teaching program for the following year, but I was not accepted. At this time, I was faced with the decision to improve my credentials and re-apply to the same program, or to try something else. Since I found I no longer held a passion to pursue teaching, I struggled with my new reality.

At this point in my life, I entered a period of uncertainty in which all paths were foreign to me: I had always seemed to know which direction I wanted to take, and which goals I wanted to pursue until this point. I was faced with a great personal dilemma. *What do I want to do with my life? What gives my life meaning? Where is my place? Where do I belong?*

I used the resources I had available and explored program options that were offered by the university I was still attending at the time. In a serendipitous series of events, I found my way to the department of nursing. Enamoured by the promise of helping others (an attractive prospect of teaching which I originally pursued), and my interest in learning practical clinical skills, my new professional goal was created. For the next two years I dedicated myself to gaining the prerequisites necessary to apply for a baccalaureate nursing program and was accepted in 2007.

In 2011 I graduated with honours and began to work as a registered nurse by the end of the year. I worked for five years in a medically complex care setting before moving into acute care, and after nearly a year I moved onto my current role as a "float nurse", working on various clinical units throughout a hospital.

Over time I noticed a growing familiar feeling of dissatisfaction and a troubling change in my behaviour. I felt a lack of recognition within the professional environment. I felt as if a scale were tipping away from personal pride in my accomplishments, becoming unbalanced by compassion fatigue and the proverbial nursing "burn out". I knew something needed to change - I knew I was not finding the sense of belonging that I sought through my status as a float nurse. I explored further educational opportunities to break up the disillusionment of my working reality. I took courses in phlebotomy, advanced cardiovascular life support (ACLS), breastfeeding, and even attained a post-graduate certification in perinatal intensive care nursing, but nothing seemed to improve my state of mind.

I found myself, once again, in a position of dissatisfaction. I was spinning at the beginning of a familiar cycle: a passive progression from goals I lost interest in, towards a pursuit of additional education. Faced with these circumstances, I ruminated on my past experiences and their influence on my present practice. *How did I end up here? What can I do*

about it to make it better? Like a metaphorical cog in the great machine of health care, my teeth began to slip and I began screeching under pressure. I tried to hold myself together knowing that to run smoothly, the whole machine relies on the individual gears to maintain power, speed, and efficiency alongside each other. I found myself wondering, *As long as the product is produced, does anyone hear these gears wearing down? As nurses, when we feel constantly in the service of others, how do we regain a sense of self that enables us to do right by our patients, day-in and day-out? What does it take to keep going within this great, challenging mechanism we call healthcare?*

I was drawn towards a Masters level of education by the promise of change, seeking an answer to my question: *How can I rediscover the passion I once held in my nursing practice?* Initially, I was soothed by the familiar routine of formal education: staying on top of readings, attending classes and completing assignments on time to receive a passing grade. It provided structure, and a much-needed reprieve from the anxiety of my workplace. However, it was not long into the start of my first class that I was presented with an ulterior perspective by my thesis supervisor: "It's not about the grades you get, it's about what you learn" (J. K. Schwind, personal communication, September 2017). It was this experience that changed the focus of my professional education to a personal perspective, exploring the depths of my human experience and how it has shaped me as a person and a professional.

As a cog within my health care metaphor, my stories and inner reflections supply the propulsion needed for me to continue being a part of a greater whole, allowing me to explore key moments in my life that set me on the professional path I am on today. I am guided by stories of transition and change from my experiences as a student nurse and as a current practitioner.

My aim is to stimulate growth through reflection, explore the origins of these feelings to reframe my future path, and to find deeper meaning and satisfaction in my professional life. By exploring a reciprocal relationship between personal and professional identity, I hope that my stories inspire other health care professionals to find their own meaning in the work that they do. By inquiring into our own nursing practice, we have the opportunity to discover meaning in what we do as nurses, and through this process find the resilience needed to work within an increasingly challenging healthcare system.

An Overview of What is to Follow

Before moving into the literature on my chosen inquiry topic, I provide a brief outline of the chapters that follow.

In the Prologue, I describe short vignettes from three different moments of my life to foreshadow the temporal nature of this journey, as I discover and explore my inquiry puzzle.

In Chapter One, I begin with the story that led me to this current moment. I describe how I found myself pursuing nursing as a profession, and where I now position myself as a current practitioner. I explain my reasons for seeking my graduate level education, which led me to the identification of my inquiry puzzle.

In Chapter Two, I present the literature review to situate the inquiry, and briefly provide background into nursing education, professional socialization, and professional identity development.

In Chapter Three, I explicate my chosen research approach, Narrative Inquiry. I discuss the key tenants, and the philosophical and the theoretical underpinnings of this method. I also explore the use of reflective practice in nursing, and the value of self-study in enlightening my inquiry puzzle.

In Chapter Four, I present stories of my personal and professional experiences, and apply the first level of analysis in Narrative Inquiry: personal justification.

In Chapter Five, I move into the second level of analysis of my inquiry puzzle, the practical justification. Using relevant scholarly literature, I explore emerging narrative threads as they form narrative patterns within my told stories. I use Social Identity Theory as a theoretical lens to critically analyze these patterns in the context of the nursing profession.

In Chapter Six, I discuss the significance of the inquiry in relation to the greater context of society, demonstrating the third level of analysis: social justification.

In Chapter Seven, I reconstruct meaning from the three levels of analysis, and write a letter to new nursing graduates in order to demonstrate the significance of my learning.

Finally, in the Epilogue, I reflect on my journey through this self-study using Narrative Inquiry. Here, I consider what I have learned from this process, and the impact that this new knowledge has on my nursing practice.

At the end of each chapter, in the *Looking Back – Looking Forward* section, I briefly summarize what has been discussed in the current chapter and briefly outline what is to follow in the next one.

Looking Back – Looking Forward

In this chapter, I described the personal circumstances that led me to pursue nursing as a profession, and my current professional situation that prompted me to embark on my inquiry journey. I outlined chapters of my inquiry process.

In the following chapter, I conduct a literature review to provide a background of the current state of research and identify gaps to justify the significance of my inquiry puzzle.

CHAPTER TWO

Literature Review

In this chapter, I review existing literature surrounding the journey from student nurse to practicing professional. I begin by briefly reviewing the history of nursing education to bring the discussion to the present and explore the concepts of transition and professional socialization. Following, I discuss student nurses' exposure to the clinical environment during formal education, and the impact it has on novice nurses entering the workforce, as well as the difficulties they face during this transition. The impact of role models (both positive and negative) will provide insight into the development of professional identity to explore its unique nature. From here, how experiential learning is used to teach nurses to reflect on and in-action is discussed as a method for personal and professional growth, concluding with my inquiry puzzle.

Although various nursing literature, particularly that found in regulations and policy, often refers to 'clients' as the recipients of care, in this study I use the terms client and patient interchangeably.

Nursing Education

By the latter part of the 20th century, nursing began to establish itself as a separate entity from medicine, evolving into a *profession* rather than an *occupation* (Chan & Schwind, 2006; McEwen & Wills, 2014). Historically, the professionalization of nursing has steadily changed from the 1860s School of Nursing model established by Florence Nightingale, who acknowledged the need for, and interest in, higher level education and training (Hoeve, Jansen, & Roodbol, 2014; Potter & Perry, 2006). Before the end of the century, hospitals established their own training schools for nurses and provided education in exchange for students' free labour (D'Antonio & Buhler-Wilkerson, 2008). Unfortunately, by 1965 it was identified by the Canadian Nurses Association (CNA) that 65% of hospital schools reported that assignments

were based more on the needs of the patient care units, rather than the education needs of the students (Potter & Perry, 2006, p. 42). As the need for trained nurses outside of the hospital environment grew, the dependence on hospital-based training declined and nursing education moved out of hospitals to form programs in colleges and universities, which allowed more control over the learning needs of students (D'Antonio & Buhler-Wilkerson, 2008). Collaborative baccalaureate nursing programs (education offered through a partnership between universities and colleges), became available to meet standardized entry-to-practice requirements in North America. By 2005, registered nurses (RNs) were required to hold a Bachelor's of Science degree in Nursing (BScN), which, due to the need for advanced critical thinking skills in health care, became the minimum requirement for licensure in Ontario, Canada (CNO, 2018a; Freeman-Gibb, Jones, Rehman, & Ragier, 2017).

Transitions and Socialization into the Profession of Nursing

Transition, or the process of changing from one state or condition to another, explores the concepts of role ambiguity, self-concept, and the outcome of interactions between individuals and their environment (Chick & Meleis, 1986). It is an individualized process that occurs over time, during which a person's patterns of behavior adapt in relation to change (Meleis, 1986). *Socialization* is the process by which people acquire their personal values and attitudes, selectively navigating social practices within one's environment, to develop skills and a knowledge base for living (Dimitriadou, Pizirtzidou, & Lavdaniti, 2013).

Holmegaard, Ulriksen, and Madsen (2014) argue that the construction of one's identity is a necessity that all individuals strive to meet and negotiate throughout life. In a reciprocal manner, the learning that takes place from the socialization process greatly influences its development (Ewertsson, Bagga-Gupta, & Blomberg, 2017a). A key element of socialization is the transmission of a cultural value system, which highlights the importance of sociocultural

relationships between individuals and their environments (Kramer, 1974). These relationships in turn, also influence identity. As students are socialized into nursing, their education and experience imbue the cultural values of the profession (Goodare, 2015). As such, a successful transition from student to novice nurse is at its most vulnerable during this time. This *professional socialization* is argued to be the goal of nursing programs, seeking to enable the transition of students by establishing the behaviors and attitudes central to their future role as nurses (Brennan & McSherry, 2007; Carlson, Pilhammar, & Wann-Hansson, 2010; Goodare, 2015).

From Education to Practice

As a result of increasing interest in nursing academia, the development of nursing theory emerged to greatly influence education and the evolution of the profession as a whole (Potter & Perry, 2006; Sibbald, Graham, & Sylvester, 2013). Various components of nursing education occur within classroom and laboratory/simulation settings to help students acquire the professional values, skills, and knowledge as a modern nurse (Ewertsson et al., 2017a). However, as Bendall (2006) reflects, the knowledge required to be successful in reality cannot be "taught in a vacuum" (p. 16). Thus, a crucial component of nursing education (as well as professional socialization) also exists in "role enactment" (Fitzpatrick, While, & Roberts, 1996, p. 508) wherein students experience the accountability of their roles in clinical practice settings. Although clinical placements offer exposure to environments that present an opportunity to develop competence in their skills, it is not uncommon for students to report difficulties with this component of their education (Beck & Srivastava, 1991; Ewertsson et al., 2017a; Goodare, 2015; Landers, 2000). In fact, Sharif and Masoumi (2005) state that students identify clinical practice as "one of the most anxiety producing components" of their nursing program (p. 1).

Despite the attempt to transfer professional values to students through formal education, in clinical practice there are often conflicting circumstances, leading to what Kramer (1974) defines in her seminal work as "reality shock" (p. 466). Reality shock highlights the disparity between the educational environment and the workplace, which challenges the idealized role of a nurse that students are socialized to imbue. While their combined education and clinical experience aims to prepare nursing students for the workforce, learning to accommodate an environment with different expectations than those within their educational programs can be particularly traumatic for new graduate nurses (Boychuk Duchscher & Cowin, 2004).

To illustrate the above point, Neary's (1997) study examined the influence of Project 2000 in the United Kingdom (UK), which marked a change in nursing education similar to the one made in Canada. Nursing education moved out of the hospitals and into universities in an attempt to ascend the profession to its expanding scope of practice. By incorporating more theory into nursing education, students felt they received less exposure to clinical skills which they would be required to perform in the work place (Neary, 1997). The concerns of former Project 2000 students from Neary's study in Europe were similar to difficulties students in the Middle East faced in clinical settings, such as the fear of doing harm to patients, a sense of not belonging (to the nursing team), and not being fully proficient as a future practitioner on registration (Sharif & Masoumi, 2005).

As Bendall (2006) observes, student programs and testing material are situated from the perspective of patient-centered nursing, and yet, in reality, nurses engage in job-centered practice. This becomes worrying, when analyzed alongside the previous discussion of new graduate nurses feeling unprepared for the workplace despite the completion of their formal education. While a focus on learning justifies a reduced workload for student nurses, as new practicing professional, these graduates will become accountable in ways they are unaccustomed

to; balancing full workloads, patient wellbeing, and ultimately, the level of competence required to maintain their licence (Boychuk Duchscher 2009; Nesje, 2015).

Difficulties During Transition

The transition period from student nurse to practicing professional continues outside the formal educational setting, where the divide between theory and practice manifests as the incongruence between how nurses want to practice, and how they are expected to practice. In relation to professional socialization, this has been identified in existing literature as a common struggle for nursing students and new graduates (Boychuk Duchscher, 2009, 2001; Ewertsson et al., 2017a). Ajani and Moez (2011) indicate that nurses who possess a great degree of knowledge in theory (such as pathophysiology, rationale for particular treatments, or educating clients), may struggle with hands-on clinical skills. This is particularly true of new graduates who, when entering the workforce, end up feeling that their lack of experience (as equated with expertise) or "not knowing" was perceived as a weakness rather than an expectation of their novice position (Boychuk Duchscher 2001; Freeman-Gibb et al., 2017; Maben, Latter, & Clark, 2006).

Studies have shown that the shock nurses experience in the professional world results from a focus on bureaucratic values, such as the importance of time on efficiency, rather than the more idealistic, patient-centered values emphasized in school (Boychuk Duchscher 2009; Maben et al. 2006; Nesje, 2015). This is clear in the study by Maben, Latter, and Clark (2006) who, when examining the views and experiences of final year nursing students within the UK, not only found that they were unable to implement a practice in the way they were taught, but that the practice environment sabotaged the ability to do this. Due to time pressures, staff shortages, work overload and being burdened with additional administrative tasks and inquiries, student nurses were unable to practice the patient-centered approaches they were trained to use, which often resulted in personal distress and an erosion of compassion from having been "stretched to

the limit" (p. 469-470). Similar findings have been reflected by nursing students in other locations including Canada, where new graduates have struggled adapting to real-world practice by encountering fear, stress, dependency on others, hostility, lack of support, disillusionment, disappointment, detachment (often leading to marginalization), feelings of vulnerability, and uncertainty (Beck & Srivastava, 1991; Boychuk Duchscher, 2009, 2001; Ewertsson, Bagga-Gupta, Allvin, & Blomberg, 2017b).

For new graduates, organizational values were found to influence acts of professional sabotage by nursing colleagues, as hurried physical care, prioritizing physical tasks over "softer" ones (i.e. talking with patients), not getting involved (with patients), and not "rocking the boat" (Maben et al., 2006, p. 470) were covert rules taught by staff nurses aimed at socializing the students into the workforce. Contrary to what students are taught, few senior nurses reinforce patient-centered messages or express the link between theory and practice, instead working within organizational and structural confines that prioritize nursing as a set of tasks (Boychuk Duchscher & Cowin, 2004; Maben et al., 2006).

In practice settings where time constraints emphasize the value of multitasking, it was found that under the guidance of preceptors who focused on the practical performance of a task, student nurses were not often given the theoretical basis of why an action or skill should be carried out (Ewertsson et al., 2017a). In an environment that drives on routine or ritual, encouraging learning experiences are curbed by a lack of support and poor role models, which further complicates a student's ability to apply what they are taught in school to their nursing practice (Landers, 2000). Resentment was found to be common among novice nurses as they became acclimatized to their reality, finding that they were not able to deliver care that met the standards they were taught to imbue (Ajani & Moez, 2011; Boychuk Duchscher, 2001; Boychuk Duchscher & Cowin, 2004; Maben et al., 2006). This resentment was directed at themselves for

being in this position, and at their education for not being able to prepare them for the weight of accountability of patient care.

Acting in a way that conflicts with one's inner beliefs and values, Jantzen (2008) argues, can contribute to moral distress and burnout, which, when combined with an unrelenting work environment that individuals feel underprepared to deal with, fails to nurture the growth of a new employee. This poses a significant issue for the retention of new nursing professionals, resulting in rising attrition rates. Currently, at an international level, the rate of new graduate nurse attrition ranges between 35% and 60% within their first year of practice, while by the second year, 57% end up leaving their first place of employment (Goodare, 2015, p. 40)

The Importance of Role Models and Professional Socialization

In a survey of undergraduate nursing students from the United States, both preceptors and instructors were found to have the strongest influence on the perceptions of students as *insiders*, or those who experienced a successful "acculturation" (Rush, McCracken, & Talley, 2009, p. 315) into the clinical setting. Similarly, stories of first year baccalaureate nursing students at an Australian university found that clinical nurses were central to student's experiences, as they were exposed to the practice setting for the first time (Jackson & Mannix, 2001).

Professional socialization, the process through which student and novice nurses learn their role, is heavily influenced by senior role models or mentors (Carlson et al., 2010; Henderson, 2002). Professional identity is developed through this socialization process and becomes internalized or strengthened through students' clinical experiences with precepting nurses. A majority of literature supports this notion and argues that the strongest influences on transitioning into a profession (as well as on professional identity), are the interactions with role models through imitative and observational forms of learning (Carlson et al., 2010; Ewertsson et al., 2017a).

As professional values tend to be learned rather than taught, observing another through role modelling is a common method of professional socialization (Carlson et al., 2010; Murray & Main, 2005). Despite the increasing workload pressures of mentors and the greater demands on their time and abilities to support other nurses, positive nursing role models allow students the opportunity to independently perform tasks which, when repeated often enough, facilitate learning (Carlson et al., 2010; Ewertsson, Allvin, Holmström, & Blomberg, 2015; Ewertsson et al., 2017a). From these successful opportunities, students emphasized a sense of belonging (to nursing), which demonstrates the consequence of self-efficacy on professional identity. Alternatively, in situations where role models demonstrate behaviours that focus on a task-orientated approach to care, it can be common for students to internalize poor practices in an effort to be accepted into the environment (Carlson et al., 2010; Ewertsson et al., 2017a; Henderson, 2002).

From an anthropological perspective, the importance of role models is highlighted by the function of knowledge as power (Holland, 1999). As gatekeepers to the skills required of nursing students, established nurses (mentors) assist novices in the transition from one status to another (namely from student to qualified nurse). Having a mentor has been shown to positively contribute to both student and graduate nurses' self-confidence, clinical competency, ability to cope with job demands, and ultimately job satisfaction (Maben et al., 2006; Sharif & Masoumi, 2005). According to Murray and Main (2005), role modelling is central to the socialization of students, as the interactions experienced during their nursing education will contribute to the development of their future skills as a nurse. Clinical experience has a reciprocal role of being the basis for, and the practice of nursing knowledge, which, depending on the style of a preceptor as previously discussed, can influence how a future nurse will practice. This becomes even more significant when we consider that, what students are taught during this time not only shapes their

notion of what it looks like to be a professional, but also influences their attitudes, commitment, and retention to the field of nursing (Ewertsson et al., 2017b; Freeman-Gibb et al., 2017).

As mentioned previously, there is often a lack of continuity between university and clinical learning settings. While reflection and discussion are often part of educational nursing programs, preceptors in the clinical setting do not always use this approach (Ewertsson et al., 2017a). Preceptors have an important role in making theory "explicit and contextualized" (Carlson et al., 2010, p. 766), by explaining what they do and see to make their knowledge understandable for students. Existing literature suggests that the focus of preceptors is often directed primarily towards the correct practical performance of a skill (Ewertsson et al., 2017a). Instead of reflecting on the nuances of an action or skill with students (i.e. why it should be carried out, or what different options or alternatives may exist), it is common for preceptors to reprimand students for a lack of success with practical skills - or not to comment at all - offering poor feedback on the student's performance. This lack of discussion has the potential to result in a lack of confidence in skills for students and poses a challenge for those socializing into profession. By helping students look past nursing as a segmentation of tasks, existing literature supports the notion of a successful socialization through greater emphasis on the development of professional identity (Hoeve et al., 2014).

When positive role models support clearly defined roles, novice nurses develop confidence in their professional identities. In a supportive practice setting, positive professional identities can flourish, further contributing to a sense of belonging, motivation, and confidence (Hoeve et al., 2014; Mirza, Manankil-Rankin, Prentice, Hagerman, & Draenos, 2019; Rasmussen, Henderson, Andrew, & Conroy, 2018). Conversely, students who experience conflict in the clinical setting are more likely to report a lower satisfaction with their education. In fact, new graduates have reported that a lack of support and guidance from senior staff has

made the transition from student to practicing nurse stressful and isolating (Boychuk Duchscher 2001; Freeman-Gibb et al., 2017; Maben et al., 2006). These findings illustrate the powerful influence a mentor can have, not only when socializing new nurses into the profession, but also on their concept of self and professional identity.

The Influence of Self on Professional Identity

Ewertsson, Bagga-Gupta, and Blomberg (2017a) explore the psychological aspect of identity-work, suggesting that the educational decision of students is about defining oneself and making decisions about "whom one wishes to become" (p.24). Rasmussen, Henderson, Andrew, and Conroy (2018) argue that professional identity and self-concept can develop simultaneously, as the interaction between self, role, and context, shape RNs perceptions. Generally, when there is an alignment between an individual's concept of self and their professional identity, job satisfaction, a sense of belonging, or meaning from one's work, is experienced (Duffy, Allan, Autin, & Douglass, 2014; Nesje, 2015; Rasmussen et al., 2018; Rosso, Dekas, & Wrzesniewski, 2010; Winter-Collins & McDaniel, 2000).

In Schön's seminal work *The Reflective Practitioner* (1983), he aims to articulate the epistemology behind the actions of skilled practitioners, introducing the concepts of 'reflection-on-action', and 'reflection-in-action' (Comer, 2016). While reflection-on-action involves looking back at an experience to make sense of it, reflecting in-action invites the opportunity to make changes in the moment, using intuitive, professional knowledge (Eaton, 2016). Jantzen (2008) makes a similar argument to Schön by exploring the learning experiences of acute care nurses in her study. The themes of learning from experience, the experience of others, and from the experience of mistakes support the notion that knowledge is gained through experiential learning. Interestingly, Daley's (2001) research findings on the experiential learning of nurses reflect a humanistic component, finding that nurses' learning was directed by the relationship

with their client(s), which reframes a traditional view of professional development that focuses solely on the improvement of skill or expertise. This interaction between caregiver and *carereceiver* can provide opportunities for mutual meaningful relationships that affect professional growth, and influence therapeutic, holistic care (Schwind, 2008).

Research suggests that individual's' membership in social groups, including occupations, generates self-related interests, thus acknowledging that professional identity can be related to personal identity (Knez, 2016). As an individual's personal identity generates behaviours that reflect their values, attitudes, and goals, their social identity (or collective-self) often aligns with the norms and behaviours of a group (Knez, 2016). Willetts and Clarke (2014) acknowledge the lack of research using the concept of social identity to describe nurses, in correlation to their professional identity. The authors recognize the contextual importance of the environment in which nurses engage, and argue for specific attention to workplace settings, and the (social) actions through which the daily demands of the profession are met.

Professional identity can develop from experiences *within* the workplace to extend to reflection *outside* the workplace (reflection in-action and on-action), challenging previous assumptions (Daley, 2001). Jantzen (2008) refers to this life-changing, experiential learning as way of accessing personal transformation that shapes professional identity, which supports the growth and development of a nurse as a "competent, compassionate, caring, and empowered professional" (p. 25). By exploring personal and professional experiences, I reflect both inwards and outwards in this way, informing the interaction between personal and professional identity.

A further support that personal and professional identity construction are mutually influencing is found in Dewey's (1938/1997) work on philosophy of experience. He suggests that all our life experiences inform all subsequent experiences, thus implying that personal and professional identity formation are mutually informing. This is well explored by nursing scholars

(Chan & Schwind, 2006; Lindsay, 2008; Manankil-Rankin, 2015; Schwind 2008) who, using Narrative Inquiry (Connelly & Clandinin, 1990, 2006) research approach, recognize this significant consideration in nursing education and practice.

My Inquiry Puzzle

W*hat is the reciprocal nature of my personal and professional identity development as a nurse?*

Looking Back – Looking Forward

In this chapter, I reviewed relevant scholarly literature to position my inquiry puzzle in the current context of health care. By briefly exploring the history of nursing education, I considered the influence of the educational experiences on nursing students and new nursing graduates, as they transition into the clinical environment. Using the literature, I explored narratives of novice nurses, and highlighted the significant impact that professional socialisation has on their experiences. Identity work, as a psychological process, highlights the influence of an individual's self-concept on subsequent identity development, and supports the significance of how personal and professional identities affect each other.

Nursing literature suggests that through personal introspection, using self-reflection and experiential learning, nurses are able to access professional development by re-constructing new meaning from a renewed understanding of their experiences. However, little research exists that fully explores this assumption, which could provide valuable insight into how to better prepare novice and expert nurses alike, in the development of a positive professional identity. It is for this reason I use a self-study method of Narrative Inquiry to explore my inquiry puzzle.

In the next chapter, I discuss Narrative Inquiry as a qualitative research method, and explore its philosophical and theoretical underpinnings.

CHAPTER THREE

Methodology

In this chapter I discuss Connelly and Clandinin's (1990, 2006) Narrative Inquiry, as my chosen research method. I begin by describing the philosophical influence of Dewey on this qualitative approach and move into the tenets of the three-dimensional space, and three levels of justifications which guide its analysis. As this is a self-study, the study design includes a discussion of personal and professional reflective practices, highlighting the types of data that are collected and constructed, and how they are used within my inquiry. As I delineate the ethical considerations to ensure that rigour and reflexivity are maintained, I also discuss how I strive to ensure my inquiry maintains *wakefulness* (Clandinin & Connelly, 2000), as a goal of Narrative Inquiry.

Method: Narrative Inquiry

As educators, Michael Connelly and Jean Clandinin were influenced by John Dewey's philosophy on the nature of experience. Dewey's philosophy proposes that knowledge grows from experience, which has two criteria or principles: *interaction* and *continuity* (Dewey, 1938/1997). Interaction is the integration of the context and culture of experience, acknowledging that, in addition to their individuality, people's experiences are always influenced by the social context of their lives (Clandinin & Connelly, 2000). Continuity acknowledges the existence of an experiential continuum in which "experiences grow out of other experiences, and experiences lead to further experiences" (Clandinin & Connelly, 2000, p. 2). Clandinin and Connelly (2000, 2004) were interested in the study of individuals' life experiences, and how this influences future growth and knowledge development. They recognized narratives as the culmination of stories that shape people's lives, and the way through which an individual's experience of the world is interpreted. In this way, and based on Dewey's criteria of interaction

and continuity, they came to establish Narrative Inquiry as a way of understanding experiences in collaboration with their participants.

As a method Narrative Inquiry uses stories to study experience, reflecting Dewey's pragmatism where knowledge is the product of interpreting the actions and outcomes connected to our lives. Inquiry, in this sense, is both a form of research and reflective decision making that explores the basis for our beliefs (Morgan, 2014). The way we choose to tell our stories becomes our narrative, which is influenced by the unique contexts of our experiences. Stories are not only a way of constructing one's identity but are also a tool to examine uncertainties we are faced with in our lives, giving us a chance to (re)interpret our world by creating new expanded meaning (Bishop & Shepherd, 2011; Noland & Carmack, 2015). In other words, what we know about ourselves is shaped by our life experiences, which are constantly changing and thus reforming our identities. Through the retelling and reliving of stories, this reconstruction of experience enhances personal and social growth, which is argued to be one of the main purposes of Narrative Inquiry (Clandinin & Connelly, 2000).

As a qualitative inquiry method, Narrative Inquiry is now increasingly used within contemporary health research (Aksenchuk, 2013; Gaudite, 2015; Kruczek, 2016; Lindsay & Schwind, 2016; Manankil-Rankin, 2015; Sharma, 2015; Thavakugathasalingam, 2016; Walji, 2014). It is emergent in nature, offering the opportunity to explore stories (lived experiences) from three commonplaces (temporality, sociality, and place), using four directions (backward, forward, inward, and outward), and three justifications (personal, practical, and social) (Clandinin & Connelly, 2000).

Three-Dimensional Space

Drawing on Dewey's philosophy, Clandinin and Connelly (2000) establish a *three-*

dimensional Narrative Inquiry space in which an experience is unraveled with the understanding that interactions are influenced by various factors. These materialize as three *commonplaces*, or "dimensions of an inquiry space" (Connelly & Clandinin, 2006, p. 479).

Temporality. Referring to the continuity of experience within past, present, and future, Clandinin and Connelly (2000) propose that to "experience an experience" (p. 50), interactions can focus on four directions: inward, outward, backward, and forward. These directions situate temporality, a dimension of an inquiry space, and represent how an inquirer can explore experience looking inward at personal influences, such as feelings and hopes, outward to the environment and social influences, and backward and forward within time. In this imagined space, a researcher is able to become self-conscious and aware of perceptions that allow new interpretation to re-tell and re-live their understandings of the stories to inform the future (Connelly & Clandinin, 2006; Kim, 2016). In this way, this commonplace reflects Dewey's *continuity*, as a criterion of experience.

Sociality. Although Dewey's influence situates interaction as central to experience, Connelly and Clandinin acknowledge that while people are indeed individuals, they cannot be understood separately from the social context in which they exist. These personal and social interactions create another dimension of Narrative Inquiry's metaphorical space, and acknowledge an individual's position within the structural milieu, including how it shapes their experience. In Narrative Inquiry, researchers investigate a particular phenomenon of interest, or *inquiry puzzle*, alongside individuals who have experienced it, referred to as co-participants. Together with their co-participants, researchers explore these personal stories (narratives), in a mutual effort to understand various personal and social conditions contributing to these lived experiences (Clandinin, 2013; Connelly & Clandinin, 2006).

Place. Place refers to "the specific concrete, physical, and topological boundaries […] where the inquiry and events take place" (Connelly & Clandinin, 2006, p. 480-481). Considering the specificity of the location in which events unfold, allows researchers and participants to explore the mutual impact of the three commonplaces on the understanding of the experience. Together with sociality, place reflects *interaction* as one of Dewey's criterion of experience.

Three Levels of Justification

Clandinin and Connelly (2000) emphasize that the purpose of an inquiry lies in the justification of research at three mutually-informing levels: personal, practical, and social. To explore an inquiry puzzle in depth, using Narrative Inquiry, these levels of influence are explored at two different stages of the research process: at the outset and at the analysis stage. At the beginning of the study, the three levels of justification provide rationale for its undertaking, in order to warrant its value in knowledge development. Later, at the analysis stage, these levels of justification provide a framework through which the stories are analyzed.

By framing my inquiry puzzle using a self-study approach to Narrative Inquiry, I use the three levels of justification as a means of analyzing my lived experiences as a person and a nurse. I apply the three commonplaces (temporality, sociality, and place) to personal, practical, and social levels of analysis to explore my past experiences as they have shaped my present personal identity, and to understand the reciprocal relationship they have on my professional identity. In addition to using the three levels of justification at the beginning of my study, to argue the value it holds for future knowledge development, I also use these levels to analyze my stories.

Levels of justification at the outset of the inquiry.

***Personal justification for this inquiry*.** This level of justification focuses on inner reflections within an inquiry space. It is where one is situated within a narrative and represents the personal significance of a phenomenon to the inquirer (Clandinin & Connelly, 2000). In other

words, as the researcher I need to personally 'justify' the choice of my inquiry interest or topic. In my self-study Narrative Inquiry, personal justification is described through the prologue and introduction, as I identify my inquiry puzzle, and my interest in exploring it. This interest is both personal and professional.

Practical justification for this inquiry. Also considered to be professional justification, this level explores the current state of knowledge surrounding an inquiry topic and addresses gaps in research concerning a phenomenon. As noted by Lindsay and Schwind (2016), Narrative Inquiry allows exploration into an existing phenomenon of experience that often arises from a personal-professional dilemma.

In Chapter Two, I explore nursing education, professional socialization, and professional identity development in greater detail, using existing literature to explore what has already been done on the topic, to identify possible gaps. In this way, I address the usefulness of my inquiry, situating it from professional and social perspectives, and justify how it could be used to open a dialogue exploring how my nursing practice is impacted by my personal experiences.

Social justification for this inquiry. According to Bullough and Pinnegar (2001), a powerful self-study must explore "nodal moments" that reveal pattern of experiences to engage readers, promoting insight and interpretation into "the larger frame of shared experience" (p. 16). In Narrative Inquiry, this shared experience is often referred to as the grand narrative (Clandinin & Connelly, 2000). Clandinin and Connelly (2004) state that self-studies have the potential to use individual's personal and practical knowledge to resonate with the professional knowledge of others, which expands the application of an individual narrative to a greater audience, inviting them to do the same. This ensures the social justification is being met, addressing the questions "So what?" and "Who cares?", allowing the possibility the inquiry findings are meaningful to a broader society.

Levels of justification at the analysis stage.

Personal justification in the analysis stage. To successfully explore this dimension of an inquiry space, researchers consider the role they play in their interactions with co-participants, acknowledging that they are also influenced by these internal and external conditions of experience. Personal conditions, such as the internal "feelings, hopes, desires, aesthetic reactions, and moral dispositions" (Connelly & Clandinin, 2006, p. 480) of a person are considered, while social conditions are more external, referring to a person's environment and surrounding forces or factors, which shape context (Clandinin, Pushor, & Orr, 2007). By using Narrative Inquiry, researchers and co-participants use relational experiences to create new knowledge surrounding a phenomenon, which can then be used to understand future experiences. Mooney (1957) relates to a researcher's investment in their study as a "personal venture", arguing its worth for its "direct contribution to one's own self-realization" (p. 155).

Due to the nature of this self-study, I am careful to recognize the existence of multiple "I"s: my (personal) participant-self, and my (inquirer) researcher-self. While my participant-self provides the field text, in Chapter Five my researcher-self presents my interim text. Ensuring the stories remain true to my participant-self, in this chapter I reconstruct two short vignettes of my childhood, two stories of my experiences as a nursing student (from 2007 to 2011), two as a new graduate (2012-2015), and three as a practicing nurse (2015 to the present).

Reflecting on these stories within the three commonplaces of Narrative Inquiry, my researcher-self recognizes the influence of social context (sociality) on my participant-self. Interwoven throughout the analysis of these stories are the shifting perspectives (temporality) of my participant-self: Inwards (through personal knowing), outwards (the influence of the surrounding environment), backwards and forwards (in reference to the past, present, and future).

Practical justification in the analysis stage. In Chapter Six I continue to analyze my stories as my researcher-self within the three-dimensional space of Narrative Inquiry. I explore my identity as a nurse, and how my self-as-practitioner is influenced within the greater context of the nursing profession. Through the narrative threads and patterns that emerge in this chapter, I use relevant literature to examine the emergent issue and to gain a deeper knowledge of their role in the formation of my personal and professional identities. By analyzing the experiences of my participant-self to extend my understanding of identify formation, I highlight "the reflective process and [yield] knowledge about practice that does not arise from daily practice alone" (Dinkleman, 2003, p. 9).

Social justification in the analysis stage. The justification of an inquiry puzzle at a social level is concerned with addressing its relevance to the whole of society. By answering questions such as "So what?" and "Who cares?" (Clandinin & Connelly, 2000, p. 120), the importance of an inquiry ascends from discovering knowledge that benefits a particular context, to that which has the potential to benefit others through the transferability of knowledge, addressed later in the Rigour section.

In Chapter Six, I examine the narrative patterns of my inquiry to understand the interaction between my personal and professional identity, and the impact of each commonplace on my experiences. Through this reflection, my self-study explores current issues prevalent within nursing practice, identifying opportunities for personal and professional growth. My research text is formed as I consider this, and I explicate the significance which may then extend past the purpose of this inquiry to issues relevant to the greater society.

Study Design

Self-Study and Reflective Practice

Dinkleman (2003) defines self-study as "(an) intentional and systematic inquiry into one's own practice" (p. 8). Dinkleman (2003) and Clandinin and Connelly (2000; 2004) reflect on experience through an educational lens, much like Dewey did. As a university professor, Dinkleman argues the importance of reflective practice for teachers, while proposing that "(s)elf-study is not the whole of teaching, but it mirrors and systematizes that part of pedagogy that is reflection" (p. 9). In this sense, self-study as a formalized form of reflection, can be synonymous with education not in the institutionalized sense of the word, but as Dewey (1916) defines it: "reconstruction or reorganization of experience which adds to the meaning of experience, and which increases ability to direct subsequent experience" (p. 76). Using a self-study method of Narrative Inquiry, I explore my personal and professional reflections in greater detail. Self-study, according to Clandinin and Connelly (2004), "holds the highest possible potential for improving education" (p. 597). As such, this experiential inquiry has the potential to offer insight into current and future nursing education and professional practice experience, my own and through transferability of knowledge, that of others.

As Clandinin and Connelly (2004) argue, a well done self-study is rich in knowledge due to the experiential base of the *self-knower*, which has the potential to reveal the educational and professional landscape that exists. In this way, understanding the self is key to understanding the "grand narrative" (Clandinin & Connelly, 2000, p. 22), or the persistent, unquestioned way of looking at things, which undoubtedly affects both personal and social experiences. If a self-study describes an experience that others can learn from, it is far from self-indulgent, and has the potential to enrich collaborative knowledge (Bullough & Pinnegar, 2001).

Reflective Practice in Nursing

Using a constructivist perspective that views experience as a basis for learning, Gustafsson, Asp, and Fagerberg's (2007) meta-study involves qualitative research that explores

reflective practices in nursing care. As an intellectual process, learning from reflection can act as an agent to make the influence of experiences, relationships, and emotions explicit, in the way that they shape an individual's values, attitudes, and self-awareness (Gustafsson, Asp, & Fagerberg, 2007). According to the authors, reflection is an internal, self-regulating process that has three directions: an introspective examination for the development of oneself, a way to explore ethical issues and challenges to one's moral conscience, and a facilitator of change that creates meaning for better understanding to guide improvement. Hem, Halvorsen, and Nortvedt (2014) argue that as intimate, demanding work, professional care requires self-reflection to prevent a carer (nurse) from neglecting their personal needs solely in favor of the other.

The concept of reflection is applied to nursing from educational programs and is further emphasized by professional organizations. For example, *Practice Reflection* is a yearly method of self-assessment currently mandated by the College of Nurses of Ontario (CNO) to maintain continuing competency as a licenced, practicing nurse (CNO, 2018b). It is a professional expectation that requires an analysis of one's practice to identify learning needs and self-development opportunities, which, when caught up in the drudges of an increasingly demanding profession, can feel like a chore. However, research suggests that reflective practice is an important component of nursing, which can be used to analyze past events and improve clinical outcomes through renewed understanding of an experience (Boychuk Duchscher, 2001; Gustafsson, et al., 2007; Landers, 2000; Sharif & Masoumi, 2005).

Despite the significant amount of research to indicate its value, reflection cannot always create meaning that results in growth – especially when it is forced to meet yearly goals as it is by the CNO. Reflecting about who we are as nurses is ultimately about who we are as persons, and meaning is often emergent in nature, rather than prescriptive (Lee, 2015; Lindsay, 2008). To this end, it is my intention to use a self-study method of Narrative Inquiry (Connelly & Clandinin,

1990, 2006) to delve deeper than the CNO's practice reflection allows. By exploring my individual experiences, I intend to discover how my personal identity is mutually informing with my professional one, and how they evolved over time in different contexts – a goal which aligns with Dinkleman's (2003) summation that "experience teaches nothing to the nonreflective practitioner" (p. 9).

Moving from Field Text to Research Text

In Narrative Inquiry *field texts* are data. As descriptive stories of experience, field texts are gathered as research material to conduct the study, and are explored within the commonplaces of temporality, sociality, and place. Field texts open up imaginative possibilities for an inquiry and capture narrative expressions within materials such as journal entries, documents, photographs, and conversations, with the intent of "'[making] sense of life as lived" (Clandinin, & Connelly, 2000, p. 78). By repeatedly asking questions surrounding the meaning and significance of field texts, the complex process of constructing research texts begin to emerge, which according to Clandinin and Connelly, is the inquiry task of researchers.

As a self-study, my personal stories constitute the field text for this inquiry. To compose these, I recall to memory specific experiences from my personal and professional life. I write each experience down on a separate sheet of paper in a style that is conversational in nature, and in order of their recall. After composing approximately sixteen stories, under the guidance of my thesis supervisor, I choose the ones that have the best potential to elucidate my inquiry puzzle.

By examining these stories as field text, I move forward into the (re)interpretation of these experiences, building on them as my researcher-self to create *interim text*. Interim texts are often situated in between field texts and final research texts and are constructed as the researcher begins to work on an analysis and interpretation that is true to the experience of the co-participants (Clandinin & Connelly, 2000). The nine stories I present in Chapter Five,

reconstructed from their written form, represent my interim text. I have divided these personal and professional stories into four categories of my life experiences: child, nursing student, new graduate, and current practitioner.

From these reconstructed interim texts, I engage in the three levels of analysis (personal, practical, social) of Narrative Inquiry to compose *research text,* while continuing to consciously acknowledge the influence of the three commonplaces on experiences. As noted by Clandinin and Connelly (2000), field texts are "woven into the development of research texts" (p. 119). By reading and re-reading my field text, I search for narrative threads and patterns and repeatedly ask questions concerning the meaning and significance of my inquiry puzzle (Clandinin & Connelly, 2000). In this way, I shift the focus of this self-study to re-present a narrative of experience, which applies to the professional landscape of nursing practice, and the reciprocal nature of personal and professional identity development as a whole.

Ethical Considerations of Narrative Inquiry Self-Study

As this self-study involves personal reflections only and does not aim to tell the story of others, the Research Ethics Board (REB) of Ryerson University has determined that this inquiry is exempt from its full review (Appendix A).

There is a temptation, notes Clandinin and Connelly (2004), to satisfy the ego in self-study, which demands moral integrity through a commitment to honest research practices to remain ethically sound (Bishop & Shepherd, 2011). To ensure this transparency, rigour and reflexivity are warranted, as with any other research.

Rigour. As defined by Clandinin and Connelly (2000), "Narrative Inquiry is an experience of the experience" (p. 189). Because of its unique focus on the retelling of stories as lived experience, the authors argue that to achieve the purpose of discovering "new directions and new ways of doing things", they try to avoid rigid structures of theoretical considerations

that concern "strategies, tactics, rules, and techniques" (Clandinin & Connelly, 2000, p. 189). In this sense, the traditional methods of judging the merits of a particular study cannot apply, which makes the pursuit of rigour more particular, due to the unfolding nature and intent of Narrative Inquiry.

Despite the assertion that the criteria for a "good" Narrative Inquiry continue to be developed, Clandinin and Connelly (2000) refer to *wakefulness* as a central goal of narrative inquirers. Being wakeful refers to the ongoing reflection of researchers to remain aware of all the intersecting aspects of human experience, in order to appropriately portray participant narratives. To ensure this, inquiries should have an *explanatory, invitational* quality, and demonstrate *authenticity, adequacy* and *plausibility* (Clandinin & Connelly, 2000, p. 184-185).

Working within the three-dimensional space of Narrative Inquiry becomes explanatory as researchers use temporality to explore the stories of participants in the four directions (backwards, forwards, inwards, outwards), while being careful to avoid causality. By considering the internal and external conditions within this space, the experiences of participants and the researcher(s) are explored, as well as how they may affect the future experiences of both.

As previously mentioned, given the nature of this self-study, I am uniquely the participant and the researcher. Using temporality, I move back and forth between the contexts of my experience, allowing for the possibility for different interpretations of events to generate new meaning, which will shape my future as an authentic professional. However, to maintain the social significance of this inquiry, and avoid the risk of self-indulgence, I continue to remain aware of my multiple "I's". To address this, throughout this inquiry I clearly communicate the distinction and use of my participant-self, as I retell, or create the field text, and researcher-self, as I explore the meaning behind the stories presented. In this way, I maintain a distinction that more closely resembles a traditional Narrative Inquiry with separate co-participants.

To fulfil the invitational quality, a good inquiry should entice others to read and respond to particulars of a story that may shape their own inquiries. By exploring my own personal and professional identity development through this process, I invite readers (particularly nurses) to engage in their own reflections of past experiences, to explore the impact that these may have had on their present practices.

To ensure authenticity, the interpretations of the participants' stories must be accurate in order to verify that the re-presented narratives are truthfully told. As this self-study involves reflection, acknowledging the fallibility of memory is one such effort to remain thorough in its intent to explore my inquiry puzzle. Recognizing the imperfection of recollections is in fact, central to the tenant of Narrative Inquiry. Clandinin and Connelly (2000) state that one of the dangers of composing narrative research texts is the construction of a "Hollywood plot" in which "everything works out well in the end" (p. 181). To ensure authenticity I remain vigilant to ensure I am not purposely adjusting the language of my experiences (as participant) for fear of being judged as a "bad nurse". Of course this requires honesty, and the disclosure of personal thoughts or prejudices surrounding certain stories may be uncomfortable for me to share. However, it is something that Lopate (1995) argues is part of the conscience of a quality personal essay (self-study).

While plausibility ensures that these storied experiences are analyzed in a logical, reasonable manner, adequacy means that the study has sufficiently captured the experiences of participants in order to address the inquiry puzzle. To demonstrate rigour in this regard, throughout this process I engage in regular reflective dialogue with my research supervisor, ensuring that careful consideration is given to the selection and order of my story presentation to aid the reader through my journey.

Reflexivity. By positioning narratives within the justifications of Narrative Inquiry we can see the interrelations between personal, practical, and social influences on our stories to gain a larger picture of lived experiences. Due to the nature of a self-study, reflexivity is an overarching theme of my inquiry puzzle, examining how my own situational thoughts, beliefs, and values inform my professional identity as a nurse (Bishop & Shepherd, 2011). Any epiphanies that emerge from stories reflect the dimensions of my human experience, particularly in terms of significance, value, and intent – three components of narrative writing that unearth meaning (Connelly & Clandinin, 1990).

Looking Back – Looking Forward

In this chapter, I described the key tenants of Narrative Inquiry, outlined my self-study design, and discussed how I demonstrate the theoretical and philosophical underpinnings of this research method to ensure a rigorous approach.

In the next chapter, I engage in the first level of analysis in Narrative Inquiry, personal justification, by presenting stories from my personal and professional life, as they inform my inquiry puzzle.

CHAPTER FOUR

Personal Justification

In this chapter, I begin with two brief stories of my childhood, framing my personal identity development within the context of my inquiry puzzle, namely, *What is the reciprocal nature of my personal and professional identity development as a nurse?*

From here, I present seven personal stories to represent my lived experiences in the field of nursing, which contribute to my professional identity development. I have divided these stories into three categories, describing significant events from my time as a nursing student (2007-2011), new graduate (2012-2015), and current practitioner (2015- present). Presenting these stories in chronological order demonstrates Dewey's view of experience as continuous and interactive in which "our experiences are developed from other experiences, and that earlier experiences lead to further experiences" (Clandinin & Connelly, 2000, p. 2). In this way, I am able to explore both my personal and professional experiences that contribute to who I am today, as a person and a nurse.

Throughout this chapter, I engage the stories of my lived experiences from the perspective of my researcher-self, careful to separate the multiple "I's" of Narrative Inquiry (Clandinin & Connelly, 1998, 2000). My participant-self tells the stories using bolded Comic Sans MS font, because it reflects my hand-writing style. My researcher-self responds to the stories using Times New Roman font.

These stories are written in present tense to make the experiences they denote more immediate to the reader in the moment in which they are told. At this level of justification my participant-self voice is dominant, with my researcher-self voice serving to reflect and ponder the told stories, demonstrating the relational quality of Narrative Inquiry.

Stories from Childhood

Discord in My World

> I am four years old in my first, and last, shared family home. As I walk down the hall of the main floor to the kitchen, I hear my parents arguing. I stand in the door, watching. They do not notice me.

Researcher-self: Family is one of the earliest exposures a child has to interpersonal relationships. A young child observing her parents arguing, two pillars of her personal care and safe-keeping, must be quite traumatic. Since my parents did not see me, there was no opportunity for an explanation to my child-self about what the argument could mean to me, and my family as a whole. I wonder, if they had seen me at this moment, how would they have comforted me.

I often wonder the effect this incident had on me as I grew up, and how it could have influenced my concept of 'care', which I now bring to my practice as a nurse.

Helping Mom

> I am seven years old, living with my mom. Every other weekend my older brother and I go to visit my dad. The majority of the time, I watch how challenging it is for my mom to attend to my brother, with his medical needs and constant mood swings. I notice how she never seems to stop working, whether at home or otherwise. She always looks so tired. I want to help her, but I do not know how – I am too young. If I cannot ease the burden of my brother, then I can control how much she needs to do for me, her second child. I stay quiet and out of the way, so I don't add to her work.

Researcher-self: What effect does the absence of my father have on my understanding of males in a caregiving role? Watching my mother taking on both parental roles could have shaped my ideas and values of what it means to be a woman growing up in society, and my understanding of future responsibilities as a caregiver. By experiencing care through my

mothers' actions towards my brother and me, she was a role model to my childhood self, shaping my understanding of what it means to care, and what it ought to look like.

> Countless times mom tells me she never has to worry about me. She says she always finds me sitting in front of the TV, as if trying to "escape".

Researcher-self: This seems how I tried to "stay quiet and out of the way". By escaping through television, I made myself invisible, a deliberate action to minimize my needs as a child. I wonder how this shaped my values as a nurse, now that I am in a caregiving role. Do I still minimize my personal needs to fulfill the needs of my patients?

Nursing Student

Pushing Through Fear

> I am in clinical placement of the second year of my nursing program. I am shadowing a staff nurse as she starts her morning care. A patient's breakfast arrives while the nurse takes his vital signs. He asks if he can be changed out of his wet incontinence brief. The nurse puts off his request, saying she does not have the time right now, and asks him to eat his breakfast until she is able to come back.

Researcher-self: What tasks are more pressing at this time for this nurse? Is her response to the patient a consequence of her workload, or worse yet, is that how she prioritizes her patient care? Is she aware of the message she is conveying to me, as a nursing student taught to practice "patient-centered care"?

> I am shocked at her response. I cannot fathom sitting in my own excrement, let alone trying to eat my breakfast at the same time. Even as a shy, unconfident nursing student, I volunteer to change him. My initiative is a reflex triggered by sympathy for the patient, despite my lack of confidence.

Researcher-self: Empathizing with the patient, I imagined myself in his situation, which evoked an intuitive reflex to help him. It seems as if my personal desire to help the patient overrode the

lack of confidence I had in my skills as a novice nurse. Perhaps knowing that the nurse was busy and unable to change the patient, I had a desire to be helpful in the same way I wanted to be helpful to my mom.

> By the time I return to the room with my supplies, another person has arrived at the patient's bedside. For a moment, I think it is the nurse returning to help me, and I feel relief.

Researcher-self: Despite my initiative, the feeling of relief suggests I wanted (or perhaps needed) the support from a mentor. Although changing a patient was a skill experienced in my first year of nursing school, my feeling suggests that I did not yet feel confident enough to be on my own.

> However, it is someone I don't recognize. I don't think to ask who she is. I feel awkward and unsure of what to do once she notices me. I nervously say I am going to change the patient, and pull the curtains past her, as she steps away. I do not have time to give into my fear of making a mistake. The patient is a witness in front of me, and the visitor is a witness behind the curtain, so I have to act professionally despite my lack of confidence.

Researcher-self: Was the pulling of the curtains to avoid a sense of performance under pressure as a student, or to protect the patient's privacy as an intuitive professional? Was my focus on the task a way of escaping, like my focus on the TV as a child? Or was this the beginning of my development of competence as a professional, recognizing the need of my patient and responding accordingly?

> To direct my attention away from the imagined judgement from both of them, I focus on the task.

Researcher-self: Learning to compartmentalize my emotions in order to complete a task, could be a coping mechanism I used to deal with stress as a child growing up, and now as a nursing

student. I wonder if my peers used similar coping situations in such situations. I do not recall being taught about this in my nursing program. Or maybe, I was too nervous to remember?

Learning to Survive

> Today, I am taken aside, again, by my community placement preceptor, and told I am not performing well enough. I am in my third year of the program and placed at a "resource center" for children and adults, a glorified daycare. I have never felt more frustrated and angry since I began the nursing program.
>
> My preceptor is a child and youth worker with no nursing background. My ability is judged by participation in children's activities, such as "circle time" when we sing preschool songs and clap hands alongside each other.

Researcher-self: The friction between what I felt I should be learning from a clinical placement, and what I was actually learning, resulted in frustration and anger. The perception I held of my preceptor as a mentor with no nursing background added to this frustration, as my overall performance was judged by, what I considered as childish activities, which I did not associate with nursing.

> I had requested a "maternal-child placement", hoping that I would be involved with post-partum or birthing care. Instead, I got placed here at the resource center. Here, I am told to be "more involved" and "enthusiastic" with children and their parents, despite the discomfort I feel, and my lack of interest.

Researcher-self: It seems as if I was still interested in learning about acute, task-oriented nursing care, such as post-partum or birthing specialties. This offers more insight into the anger I felt with my community placement, from a discrepancy between my expectations and the reality. Also, having acclimatized to a responsibility for self-care from a young age, it would make sense that I did not identify with the childhood activities expected at my placement.

I have already had a number of meetings with my preceptor, faculty advisor, and a supervisor of the nursing program to discuss my situation. My options are to either make it work or take a year off school and hope for a different placement next year. I have no intention of slowing my progression through the program, so I continue.

Researcher-self: The words "slowing my progression" suggest my desire for an ever-forward motion towards a goal. What was the goal I had during this time as a student nurse, which I felt I was being held back from?

I would much rather be learning new, useful information that I can take with me through graduation, rather than trying to plan trivial activities to engage children in play. I would rather learn how to develop and perfect my critical thinking skills so I can become a valued professional, rather than another voice in a choir of preschool songs.

Researcher-self: Again, the pursuit of a specific goal is evident. This offers insight into the answer to a previous question, highlighting my desire to continue in acute care rather than being "another voice" within a children's choir.

This is reminiscent of my determination as a child to be directly involved in the help of one person (my mom), or a single parent family (my mom, brother, and myself). In society, an incomplete nuclear family may be seen as a "broken family". Perhaps coming from a broken family as a child has influenced my inability to identify with children in a community? This could explain the unconscious discomfort I felt in a placement among other families and their children.

Every day I come here to my placement, I feel like I am trying to prove my worth, afraid every week that my preceptor will see through me – see that I am just biting my tongue to get through this - and fail me. The only thing I am learning is how to survive, and how to fake it until I make it through.

Researcher-self: There is a sense of struggle to complete this placement. My preoccupation with "faking it" suggests I have already decided I will take nothing from this placement, perhaps leading to a self-fulfilling prophecy.

New Graduate

On My Own for the First Time

> I am excited for the first shift of my first nursing job in complex continuing care. Now that all my orientation has finished, instead of shadowing another nurse, I am on my own with an assignment that is fully my responsibility. I am comforted by the fact that it is a night shift, and that the flurry of activity during the day is more subdued in the evenings.

Researcher-self: I felt enthusiastic and prepared to begin working on my own, out of the shadow of another nurse, with an independent assignment. What influenced this enthusiasm? Was it the result of a successful orientation to the unit? Who were the nurses I worked with during this time, and were they effective mentors who contributed to these feelings?

> Before taking patient's vital signs, I check in to introduce myself to them and their families, just as I have done dozens of times as a nursing student. Everything is going well so far. After I am confident that my patient assessments are complete, I look at the medications I need to give for the evening. I notice the times they are to be given, pages long and written in neat, organized boxes, and see that some of the medications are staggered in times. I remember from school that an hour window before and after scheduled times is acceptable. However, after assessing all my assigned patients, I am already past the safe window of medication administration.

Researcher-self: Having started out with confidence, it seems like the time I took to be thorough in my care (as practiced during my time as a nursing student) has made it difficult to follow the "rule" of safe medication administration times. Despite following the process learned from my

nursing program, this is the first instance of contradiction I encounter between school and the workplace reality I am faced with as a new graduate. I wonder if this is a common finding among new graduate nurses.

> The call bells start to ring up and down the halls, and I assume they are my patients, asking to be toileted or to go to bed, just as they did around this time when I was still on my orientation.
>
> My anxiety, which has already started to rise, gets increasingly worse as I flip through the medication records. I try to prioritize my care. How can I fulfill their care needs, and get their medications on time? I do not know what to do.
>
> *But, I should know what to do*, says a little voice in my head.

Researcher-self: Being overwhelmed by my inner critic seems to further hinder my progress. The tasks I did as a student with my preceptor, became a major obstacle in my clear thinking and problem solving. The coping style I used previously, which is to minimize emotions to complete a task, would be ineffective here, as my anxiety rises to the point of paralysis. I wonder what prevented me from asking for help from my co-workers. Was the social environment of the unit not conducive to collaborative nursing care?

> I feel a rising panic. My feelings bubble up into tears. I do the only thing I can think of. I go to find the charge nurse.

Researcher-self: My emotions were so overwhelming that I did not have enough confidence to make the decision on my own. Feeling helpless, my conditioning as a nursing student drives me to seek "an expert" to rescue me.

Who did I go to as a child when I needed help? If I was trying to care for myself so I did not have to ask my mom for help, what did I do when I was not able to? Maybe crying was a method of self-care, a way to soothe myself as a child, which provided an outlet for my emotions

which I use to this day. If I avoided attention from my mom as a child, it would have been difficult for her to teach me a different reaction to stress.

> Looking at my face, the charge nurse seems surprised, and annoyed. Stumbling with my wavering voice, I manage to explain I am having trouble with my assignment. After some hesitation, she leads me back to the unit.

Researcher-self: I may have unconsciously been expecting the annoyance of the charge nurse, which influenced the guilt from the little voice in my head telling me I should know what to do.

As a child, if I asked my mom for help, was she annoyed then, as the charge nurse is now? This perception could have further influenced the guilt I felt asking the charge nurse for help. In both of these situations, I expected to be able to perform on my own, but could not. However, it is possible that the responsibility I felt for my patients is what drove me to eventually ask for help, overriding my self-imposed tendency to tough it out on my own.

> She tells me, *Medications always come first, then patient care!*
>
> I think to myself, *Patient care should come first!* But, I am too distraught to care right now. I need her help. I need her to tell me what to do.

Researcher-self: It seems my personal beliefs are suppressed by the professional expectations. This is a vulnerable point in my professional identity development, where I am overwhelmed to the point of sacrificing my values to accept help. Nursing is just a job to me at this moment, unaffiliated with my desire to help others. This kind of help is troubling, and seems to represent a sacrifice that I make of my personal identity for the survival of my professional identity.

The Need to Do My Best by My Patient

> It is five years since I started on this complex continuing care unit, my very first nursing position. I am rushing to feed, wash, and get my patients up in preparation for their usual appointments with physiotherapy or for time with family. I have become

familiar with the routine. There is always a lot to do in the short period of an eight-hour shift. If I end up taking too much time with one patient's care, the care of another must be cut short or I will fall behind on everything else. It's like a domino effect. This is not an uncommon occurrence for me, but I prefer to take the time to do my best by my patients.

Researcher-self: It seems like I have come to terms with the amount of time it takes me to provide quality care to my patients. Whereas before I was focused on the boundaries of time, I acknowledge that I fall behind because of my professional value to prioritize direct patient care. This demonstrates that I have adapted to my reality in a way that comfortably allows my values as a person to complement my values as a professional.

Today I have a new patient who is on isolation for C. Difficile: a tenacious bacterial infection of the gut, which usually results in uncontrollable diarrhea. My patient is completely non-verbal on top of being incontinent, which puts her at high risk for skin breakdown. This is all the more reason to keep her clean. Her diarrhea is relentless, and each time I clean her and put a new incontinence brief on, she needs a new one before I get much further into the rest of her morning care. I do not know if it will ever finish, but I need to keep moving forward.

Researcher-self: Despite my tenacity through a seemingly endless task, I am persistent and follow a goal of care, which I felt was my responsibility as the patient's nurse, who wanted to do the best by her. This sense of dedicated care takes its toll on an individual. I wonder if this is how some nurses burn out.

It is a half hour before shift change, and I am still trying to finish. As I circle past the patient's isolation room, I notice the recognizable odor, signaling another bowel movement. I am absolutely exhausted. I still have to put a couple of patients back to bed for the evening.

It is even closer to shift change now, and I am on my way to the nursing station to chart. I walk again past the isolation room and the smell of stool has gotten stronger. I try to ignore it. The next shift is coming on soon, and they can deal with it.

I still have work to do – haven't I done enough?

Researcher-self: For the first time, my personal exhaustion seems to suppress my feelings of professional obligation. I try to rationalize it by convincing myself the next shift could deal with it. By using the word "it", I am dehumanizing my patient, implying that her care is now a task to be checked off a list, in order to meet the deadline of shift change. Similarly to when I was on my own for the first time, nursing has become just a job to me, suggesting that sacrificing the values of my professional identity became necessary for my personal survival. Must one identity always be sacrificed for the other? Perhaps my status as a new graduate made it especially difficult for me to find a balance between the two.

I'm ashamed at how long it takes me to recognize that this is not me.

Despite how exhausted I am, and how much I still need to do to finish work on time, I go in to change my patient's bedding. I need to do my best by my patient.

Researcher self: Although my actions seem well-intended, they demonstrate a sacrifice between personal exhaustion and professional obligation.

Current Practitioner

Unconditional Care

It is now seven years since I became a registered nurse. For two years now, I have been a float nurse working on different units throughout the hospital. Tonight I am working on a busy orthopedic surgery unit. As usual, I am behind.

Researcher self: Why is being behind still usual for me seven years later? Could the issue be time management skills, or is this because I am still "doing my best by my patients"? Perhaps

working as a float nurse is hindering my ability to develop a regular nursing routine. If I am on different units every shift I work, it would be difficult to develop consistency.

> While I have an ear out for the bed alarm of one of my patients, a confused lady who is high-falls risk and constantly tries to get out of bed on her own, I am trying to administer my medications on time, keep on top of my charting, and complete another patient's pre-op paperwork.

Researcher self: Most of these tasks are similar to the ones I described working within a complex continuing care setting, with some new ones added due to the acute nature of hospital care. A familiarity with similar tasks suggests a natural progression in time management skills would take place, and yet, seven years later, this is still an issue for me. What prevents me from improving or moving forward? Is this just the nature of nursing work?

> As I hear the familiar sound of a bed being pushed down the hallway, the unit soon fills with the screams of a new admission, a young girl, most likely in her 20s, who has a leg fracture. She is in tears, with mascara running down her cheeks, yelling loudly for someone. Her mother and her boyfriend are following meekly behind, their heads cast down. It bothers me how they seem to be ignoring her, despite following the bed down the hall and into the unit. The girl continues to call out, twisting her neck to look for them.

Researcher self: Assuming these visitors were her family, seeing them ignore her in distress, bothers me. The level of involvement my family had in each other's lives (particularly between my mother and my brother), is a stark contrast to this situation, which makes it uncomfortable for me to watch.

What could the patient herself have been feeling? Were the people following behind her really her mother and boyfriend, and was she really looking for them or someone else? As a young girl, she could have been terrified by the situation, calling out for comfort from her

family. This would have been the exact opposite of my actions as a child, suppressing my emotions to stay quiet and out of the way, regardless of my needs.

> Another nurse has this girl as a patient. I hear snippets of their conversation, as I travel up and down the hallways trying to attend to my own patients. The girl seems absolutely hysterical, swearing and yelling out "Mom!" while continuing to berate the whole situation and everyone involved. I hear the nurse in the room tell her not to move her leg, and explains how her fracture could worsen if pressure is put on it. It seems like the girl is not listening, and she continues to yell and cry out in pain. Luckily there is a private room available, and she is placed there in an attempt to prevent her disturbing the rest of the patients.
>
> Her visitors continue to stay out of sight, but present outside the room.

Researcher self: I express greater concern for the other patients than for the girl. Could I have been too distracted by her visitor's absence and lack of concern to develop sympathy for her? Perhaps I was too shocked by their insensitivity to the girl's cries that I did not pay much attention to her either.

> Despite all the verbal abuse and yelling, I am amazed at how the nurse maintains her composure, continuing to speak in a normal tone to the girl who yells over her, seemingly not listening. I am impressed by her ability to stay calm, as I often find it difficult to control my emotions in similar situations. As the nurse leaves the room, I can see it is obviously affecting her. I can see it in her eyes, and the way she looks like she is holding her breath, allowing only a small sigh to escape once she gets away from the bedside. It is the way she walks with her hands stiffly at her side, her defensive stance armed.
>
> All I can think is, *Thank God she isn't my patient!*

Researcher self: I wonder who takes care of the caregiver. How will this nurse care for her own frayed nerves?

> I immediately feel guilty for thinking it, and I am ashamed that I feel little-to-no sympathy for the patient herself. In the back of my mind, I know a great part of my anger is because I feel she is disturbing the other patients - people who are also in pain and trying to sleep - in the middle of the night with all of this drama. My personal feelings are that she is acting ignorant and selfish, and yet my professional thoughts as a nurse tell me I cannot value patients over each other.
>
> Although they are gone now, I also cannot get it out of my mind how her visitors – people she knew- could stand outside the room listening to her yell out like that, and stay hidden.

Researcher-self: I think on how nurses are expected to be there for all patients, even if their own families are seemingly rejecting them. The nurses are expected, under any circumstance, to maintain their compassion and professionalism. But, at what personal cost?

Determined to Support My Patient

> A week later I am working in the ER. Coming in for a night shift, I am thrown into disarray before I have a chance to acclimatize.

Researcher-self: There is again this sense of always being behind in tasks or a need to "catch up". Present in my experience as a new graduate, it also exists in my present as a current practitioner.

> Receiving shift report from the day nurse, I discover that one of my patients is an elderly man who has fallen and broken his hip. His family is at the bedside. They have been there since the morning, waiting to speak to a doctor, and to ask for an analgesic. The day nurse tells me that a doctor came recently to see the patient and

to order Morphine. However, since the patient has no IV access, this was not yet administered. I do not blame the nurse – I know how overwhelming it is in the ER.

Researcher-self: In the context of the ER, it seems common for nurses' to fall behind on tasks, or become overwhelmed by the environment. In this way, I do not feel like such an outcast. Maybe I found my place of belonging.

I am moved by the family's patience despite their worry. I want to do what I can to get this man his Morphine before anything else, now that the order he was waiting for finally exists.

Researcher-self: In school I was taught that pain is the fifth vital sign (along with heart rate, blood pressure, respirations, and temperature), and in my practice, I consider it just as important to address promptly. Aside from empathizing with the patient and his family, as they watched and waited for his pain to be addressed, my professional responsibility urged me to prioritize their needs.

This is an interesting contrast to the previous story, in which I found it difficult to sympathize with the young girl with the broken leg because of her absent family. Although she too was in pain, her suffering was not in silence. For some reason, these factors influenced the gratitude I felt for not being responsible for her care. Could this have something to do with my experience of family and caregiving as a child?

Grabbing my supplies, I go to the bedside. I explain to the family that he will receive his Morphine intravenously. I surprise myself by successfully starting the IV on the first try, as I usually have a poor success rate and have to ask for assistance.

Researcher-self: Similar to the story about changing a patient's incontinence brief when I was a nursing student, I doubted my abilities to perform a task on my own, and am surprised at my success. In this situation, despite my history of unsuccessful IV starts, I am not discouraged to

try. In both instances, my initiative seems to act as a reflex triggered by a personal desire to help, consequently overriding the lack of confidence in my skills.

> Returning to the nursing desk, I learn my patient has a bed on an inpatient unit. The hospital administration puts pressure on staff to move patients quickly out of the ER, so I know I have little time to finish my task, and administer the IV Morphine before his transport arrives.
>
> As I prepare the medication, I am constantly interrupted by other patients and nurses alike. As usual, I am frustrated by these interruptions and how easily I am distracted by them. However, it is still early in my shift, and I have the determination to focus on getting the task done.

Researcher-self: I am empowered by the ability to give the patient relief from pain with the Morphine. Despite regular interruptions that tend to frustrate me, I am able to work through them because of the personal and professional value the task held for me: personally, from the need to relieve another's suffering, and professionally, from the morals I hold as a nurse.

When I was a new graduate nurse on my own for the first time, my story describes how I was overwhelmed by a shortage of time to meet medication administration times. As a current practitioner in this story, I am able to ignore the time constraints for my care and focus on what I want to accomplish. What has influenced this change?

> I manage to set up the Morphine infusion seconds before the porter arrives to take the patient upstairs. I do not know how, or if, it helps him the way I imagine it in my head, but I am hoping it did. I am proud of myself for working so efficiently.

Researcher-self: I feel a sense of pride in my accomplishment. This seems to represent an alignment between my personal and professional values, in which I am able to fulfill my personal desire to help others through the work I do as a nurse.

Fear and Fatigue

Two years since starting work as a float nurse at my hospital, I hear of the first serious attack on a nurse. From the bits of gossip, I gather the nurse, who worked in acute mental health, sustained serious injuries when she was violently attacked by a patient. I hear that she has a couple of young children at home that will need care.

Researcher-self: What meaning does this hold for me as a person and a professional hearing this story? Considering the personal value family holds as a part of my identity, hearing that this nurse has a family at home that relies on her, could have made this news more distressing for me to hear.

The news travels fast among the float nurses because we go everywhere throughout the hospital.

"She's never going to work again"

"She may not be *able* to work again"

"I'm never going back there – I refuse"

All these conversations between nurses make me anxious. It could have been any one of us. It could have been me. I think about all the things I do as a nurse, and how I step into people's lives at their most vulnerable moments. I think about how I regularly strain myself mentally, physically, and emotionally as I do my nursing care. Every thanks received from a grateful patient or family is easily overshadowed by the hunger in my belly, and the pain in my back from often standing so long without food and rest. The tears I cry at work are my brain's way of telling me to stop and rest, because I am constantly going and cannot will myself to stop when there is so much more to be done…

Researcher-self: I seem to put the well-being of others before my own. Naturally, my body cannot keep pace with the increase in my personal needs (ex. hunger, pain, comfort), which

result from overwork in my professional life. For the first time perhaps, I may be questioning my decision to become a nurse. I never seem to be satisfied by the results of my efforts.

There are still meds to be given.

There are food trays to set up for those who cannot reach.

There is someone in the worst pain of their life.

Someone's loved one has been lying in the same position for hours.

New orders have just been written.

Someone is waiting for their paperwork so they can finally be discharged.

What is taking me so long?

I deal with these issues on a daily basis, for 12 hours at a time.

I hear a voice from my past, "*Don't worry about your patients, they don't worry about you.*"

Yet, I want to do best by my patients. I give everything I can, but the demands never stop. It is never enough.

Researcher-self: Although, sometimes I seem to feel ready to give up, I still try to do best by my patients. I may have developed this overwhelming sense of responsibility from my desire to help my mom. Through the work I do as a nurse, I am able to address this desire until my physical, mental, and emotional limitations start surfacing.

In this story, just as the ones before, there seems to be tension between my personal and professional values: the quality of care I want to provide, and the care I realistically can give, within so many external constraints. Whereas, once these values were complementary and positively motivating, here, I express feelings of defeat. What organizational and social barriers may have influenced these feelings?

Now, I feel like I am the one who needs care. Because, if I have nothing, I cannot give anything!

Researcher-self: This acknowledges a shift in the perception of myself as caregiver to someone who requires care. The powerlessness and the moral struggle I seem to express in these stories, demonstrates the inextricable connection between my personal and professional identities values, in a way that offers a sense of purpose, and a meaning to my life.

Looking Back − Looking Forward

In this chapter, I engaged in the first level of analysis, the personal justification, of my inquiry. Through the three-dimensional space of Narrative Inquiry, I revisited stories of my lived experiences temporally, as my participant-self, starting with stories from my childhood, and moving forwards into my positions as a nursing student, new graduate and current practitioner. As my researcher-self, I engaged each story to reveal the personal and social contexts of my experiences, in an effort to understand the significance that each interaction may have had on my present circumstances.

In the next chapter, I engage in the second level of analysis, the practical justification of my inquiry. Here, I situate my inquiry puzzle within the broader context of the nursing profession, and explore the current state of knowledge surrounding personal and professional identity formation. Using Social Identity Theory as a theoretical lens, I explore narrative threads that emerge from my stories to form two narrative patterns: vulnerability and belonging.

CHAPTER FIVE

Practical Justification

In this chapter, I engage in the second level of analysis in Narrative Inquiry known as practical justification. At this level, the voice of my researcher-self becomes stronger than my participant-self, in contrast to the first level of analysis, personal justification.

I begin with a brief review of different perspectives on identity formation, to situate the chosen theoretical lens of Social Identity Theory (Tajfel & Turner, 1979, 1986), and the influence of relevant concepts to this inquiry. Following, I explicate the Social Identity Theory, before I apply this lens to my lived and told stories.

As I looked for narrative threads among my nine stories, I discovered narrative patterns that emerge. These threads comprise of similar or repeating words, phrases, and experiences, which integrate into a larger structure, or pattern, offering greater insight into my inquiry puzzle, how personal and professional identity are mutually informing. Using the Social Identity Theory lens, I reflect on these patterns and integrate relevant scholarly literature to gain their deeper understanding. Drawing on Dewey's philosophy of experience as continuous, interactive and situational, and Clandinin and Connelly's (2000) three-dimensional space (temporality, sociality, and place) throughout the analysis, I explore how my lived experiences influence meaning-making, and consequently, my professional identity formation.

Relevant Perspectives on Identity Formation

In this section, I briefly review the following perspectives of identity formation, and consider their relevance to my inquiry puzzle: W*hat is the reciprocal nature of my personal and professional identity development as a nurse?*

The Subjective Self

The nature of identity has its origins in the philosophy of the Mind-Brain paradigm, in which the sensation of brain processes, or mental states, allow individuals to gain a sense of self (Polger, 2009). William James (1892), a philosopher and psychologist, referred to identity as a subjective self, or "self-as-I[me]" (McAdams, 2001, p. 104), in recognition that the actions of human beings are intentional and reflexive, acting on desires and beliefs to accomplish goals. Over time it has been disputed across and within various disciplines, such as philosophy, psychology, and sociology, which propose its integration with a wide range of roles, relationships, and elements, from both within and outside the individual. Whether it is personal or social, conscious or unconscious, or based on the nature versus nurture perspective, identity rests on the idea of "who one is, [and] how one defines oneself" (Marcia, 1993, p. 3). Essentially, it is seen as a holistic sense of self – the way in which we understand ourselves as influenced by the amalgamation of factors.

Identity has been explored mostly within the field of psychology, with varying emphasis on its processes (*how* do people develop their identities), and content (*what* identity is). Historically, greater attention has been given to its processes, particularly in the field of developmental psychology, beginning with Erikson's Theory of Psychosocial Development (1963, 1968).

Erikson's Theory of Psychosocial Development

Building on Freud's concept of human psyche, Erikson's theory expands outwards, and concerns itself with the "constructive necessity of social organization in the individual's development" (Erickson, 1968, p. 47). Comprised of eight life stages, this theory associates each stage with a conflict, or crisis, which must be overcome by individuals within certain age groups, in order to move forward and successfully adapt to their environment. In the fifth stage of 'Identity vs Role Confusion', a period of time marked by late adolescence and early adulthood,

individuals develop a deeper sense of self and personal identity (Cole, 2001; Erickson, 1963, 1968). According to Erikson, individuals at this stage begin to experiment with a range of social roles, with the intention of creating an ideology that integrates their personal beliefs, values, and commitments (Klimstra et al., 2010; McAdams, 2001). Erikson views this time as a phase in which an individual learns to navigate a reciprocal relationship with society, facing tasks that mark the beginning of adulthood, such as finding a job, and learning to become a citizen (Marcia, 1966). Without the need to identify themselves within society, Erikson's theory assumes children typically do not have an identity (McAdams, 2001).

Marcia's Identity Status Model

Marcia further elaborated on Erikson's theory, laying the foundation to further develop theories surrounding adult identity establishment (Hurrelmann & Hamilton, 1996; Marcia, 1966). Marcia (1993) establishes the formation of *ego identity* as a "major event in the development of personality" (p. 3) and identifies two key processes of identity formation: *exploration* and *commitment* (Galliher, McLean, & Syed, 2017; Klimstra et al., 2010; Schwartz, Zamboanga, Luyckx, Meca, & Ritchie, 2013). Exploration refers to the tendency of individuals to seek and compare various alternatives to identify with, from within their social environment, whereas commitment represents the decision to adhere to one, or more, of these alternatives (Galliher et al., 2017; Marcia, 1966; Schwartz et al., 2013). Parallel to Erikson's stages of psychosocial development, the consideration of identity alternatives is assumed to represent the beginning of adult identity formation, in which one enters into adult roles such as partnership, parenthood, or employment (McAdams, 2001).

Professional Identity

Situated in the occupational domain, Knez (2016) proposes that professional identity can be better understood in terms of a work-related self, or "an individual work identity" (p. 2), and

that self-concept, or an understanding of self, is a prerequisite for its development. Evidence suggests that the formation of a personal identity is correlated to psychosocial adjustments, and that professional development is important in the formation of adult identity (Knez, 2016). This work-related (professional) self can be seen as a "higher order construct" (p. 2), evolved from employment in relation to its association with self-related interests and personal motivations. In this sense, our personal and social identities are involved in the formation of our work identities, and employment can be seen as "a pervasive life domain and a salient source of meaning and self-definition" (Dutton, Roberts, & Bednar, 2010, p. 265; Knez, 2016).

When employees are empowered by discovering meaning in their work, they are more likely to develop their capabilities, affirming their personal value or self-worth (Baumeister, 1991). Research shows how employees are more likely to a have a positive professional identity when they are involved in organizations that they identify with (Dechawatanapaisal, 2018; Lee, 2015; Singh & Aggarwal, 2018). In nursing literature, job embeddedness, or the extent that employees feel a strong "sense of fit" (Dechawatanapaisal, 2018, p. 1382) to their work setting, has been shown to affect personal identity, improve quality of care and patient safety, and predict intention to quit, along with employee burnout (Alarcon, 2011; Jiang, Liu, McKay, Lee, & Mitchell, 2012; Kolodinsky et al., 2018; Mitchell, Holtom, Lee, Sablynski, & Erez, 2001; Singh & Aggarwal, 2018).

Ways to Explore Identity

In terms of the content of identity and exploring what it is, Galliher, McLean, and Syed (2017) propose four levels of analysis. At the broadest level, the cultural and historical context of identity sees its development contingent on shifting cultural norms, values, and attitudes. Systems of power and privilege, access to resources, and capital, all influence identities available for individuals to experience. The second level is composed of social roles, and how our

relational self can be defined through group memberships. Socialization practices are the most influential at this level, as they communicate cultural messages and shape our understanding of what behaviours should be avoided or hidden. At the third level, aspects of personal identity are explored across domains, such as gender, sexuality, politics, ethnicity, religion and occupation. These domains interact in various ways, and across different roles throughout an individual's life, each with fluctuating degrees of significance. Lastly, the fourth level of analysis is based on the everyday interactions, or lived experiences, of individuals, which views identity as "an internalized and evolving story of self" (McAdams, 2001, p. 102).

By providing a phenomenological perspective to identity formation, the importance of the previous levels of identity analysis is manifested in individual behaviour, allowing insight into the meaning of life events. In other words, the stories people tell convey important aspects of their lives and help to identify which interactions are the most meaningful to them. Subsequently, these interactions, or lived experiences, shape their sense of self, or identity.

Despite the prevailing debates surrounding identity, including what it is and how it is formed, research across various disciplines has acknowledged a multitude of influencing factors on its development. In this self-study, I use the three-dimensional space (temporality, sociality, and place), in tandem with the fourth level of Galliher et al.'s (2017) identity analysis, to explore stories of my lived experience in an effort to understand how my personal and professional identities are mutually informing. The nine lived and told stories form a narrative from which I examine the socio-cultural influences and the interactive impact over time on identity formation. For this reason, I searched out the theoretical lens that would best enlighten my inquiry puzzle. The Social Identity Theory (Tajfel & Turner, 1979, 1986) is the selected theoretical lens, which I will elaborate in the next section.

Social Identity Theory

Social Identity Theory proposes that our personal identities, or psychological underpinnings, are formed based on the influence of the social categories, or groups, to which we belong (Knez, 2016; Tajfel & Turner, 1979, 1986; Willetts & Clarke, 2014). Within this theory, a tendency towards self-categorization exists, in which we define ourselves based on two functionally independent representations of our identities: our *personal self* and our *relational/collective* self (Knez, 2016). In other words, our identities can be influenced by (i) how we define ourselves as individuals by relying on our perception of what makes us unique (i.e. personal attributes, thoughts, feelings, experiences), personal self, and (ii) how we align with the social relationships we form, the collective self. Given this interplay, it is possible to suggest that the stronger an individual identifies with a group, the more the group will influence their attitudes and behaviours (Hirsh & Kang, 2016; Knez, 2016; Willetts & Clarke, 2014).

Within the three-dimensional space of Narrative Inquiry, I use temporality and its four directions, to move backwards, exploring my childhood experiences within the most influential social group at this time in my life - my family - and examine how they have shaped my personal identity, or sense of self. Moving forward, I explore my lived experiences as a nursing student, new graduate, and current practitioner, to consider the effects of each interaction on my developing professional self, identifying as a member in the group of professionals known as nurses. At each juncture, I move inwards to examine personal influences, such as feelings, and outwards using the chosen theoretical lens to examine the effects of the environment (place) and social influences (sociality).

By exploring lived experiences from different periods of time within my life, an opportunity exists to learn how my professional-self, that is, my current identity as a nurse, has formed based on previous experiences, including my childhood. Ideally, given the reciprocal nature of identity formation, this also provides insight into my personal identity development, in

the way that Knez (2016) discusses the relationship between self and memory, supporting that "we are what we remember, and vice versa. Self is, therefore, a product of its past, its memories" (p. 3) in every aspect of our lives.

Narrative Patterns

As I immerse myself in personal and professional stories of self, there are several narrative threads that join to become two, recognizable narrative patterns, which offer insight into my inquiry puzzle. By using Social Identity theory, I examine the threads *vigilance* and *self-sacrifice*, as they form the pattern of *vulnerability.* Afterwards, I examine the second pattern of *belonging*, and its threads of *identity disruption* and *isolation.* In both patterns, the reciprocal relationship of personal and professional identity formation is further explored, which shows how my past experiences do indeed shape subsequent experiences across my personal and professional life.

Vulnerability

Susceptibility to harm is an ever-present part of the human condition, and an unavoidable part of life as individuals interact with their environment (Angel & Vatne, 2017; Daniel, 1998; Sellman, 2005; Thorup, Rundqvist, Roberts, & Delmar, 2012). Threats of this nature can be external or internal, affecting physical, mental, social, and/or existential well-being. In society, some individuals are more vulnerable than others due to various circumstances, requiring support from others. This, according to Angel and Vatne (2017), has influenced the establishment of social structures in society used throughout politics and social planning.

Vulnerability has been considered a key concept in nursing, as nurses engage patients within this exposed state, seeking to meet their needs and protect them from harm (Morse, 1997). Literature suggests that the patient role itself is an antecedent to vulnerability, and that because illness creates the need for engagement in a therapeutic nurse-client relationship, nurses hold a

high level of responsibility in their care (Angel & Vatne, 2017; Odland et al., 2014; Thorup et al., 2012). This literature also demonstrates, however, a mutual vulnerability between nurses and patients, in which nurses are exposed to threats through their involvement in the caring relationship. As patients demand trust from their professional care providers, nurses' practical, relational, and ethical attitudes may be challenged in ways that leave them vulnerable and susceptible to suffering.

Thorup, Rundqvist, Roberts and Delmar (2012) acknowledge a scarcity of empirical studies that focus on nurses' experiences of suffering and their own vulnerability. Developed over time, nurses' personal attributes merge with their professional identities to form ideas of what is right and wrong (their ethical formation) which can, inevitably, affect the care they provide. In their study, the authors confirm that nurses integrate their own painful life experiences as persons with their professional identities. Personal insight into grief and suffering shaped how these nurses responded to ethical and existential questions raised in their practice. Nurses acknowledged that their identities were influenced by the experiences in their lives, which subsequently affected their ability to engage with patients. For example, one nurse stated "[i]f the situation reminds me of my own family…then I don't know if it's my grief or the patient's grief, and then I am of no use" (Thorup et al., 2012, p. 431). This provides valuable insight into the concept of mutual vulnerability within the nurse-client relationship. If vulnerability is defined as an individual perception of threats or challenges, by exploring the influence that these challenges have on an individual's perception of self, insight can be gained into its influence on personal identity development, and its effect on professional identity.

Based on Connelly and Clandinin's (2006) Narrative Inquiry, interactions are central to experience. Despite our individuality, the social context of our environments shape how we live and understand our lives. By starting with personal stories of my childhood, I am able to identify

how the concept of vulnerability forms a narrative pattern in this self-study. Using Social Identity Theory, I demonstrate how the interactions within the earliest and most influential social group in my life (my family), shape my understanding of this concept, and ultimately, how my perception of it influences how I identify with my role as a nurse.

My childhood vulnerability. Research suggests that single-parent households are characterized by greater levels of instability and uncertainty than nuclear families, in which the loss of a parent may contribute to feelings of emotional vulnerability in children growing up in these environments (Sohail & Shamama-tus-Sabah, 2016; Zartler, 2014). As previously mentioned, Erikson's theory (1963, 1968) proposes that the period of young adulthood is when individuals begin to develop a stable self-identity, navigating their role in society based on their previous social life experiences.

Theoretically, as a child growing up in a divorced household, this suggests I was in an emotionally vulnerable position, which would affect my personal identity development as an adult, and subsequent professional identity as a nurse. My childhood stories, however, present an ironic experience of vulnerability, in which I shifted focus away from myself as such. Instead, I recognized the vulnerability of my brother (despite his older age), requiring the majority of my mother's attention due to his medical issues, and my mother herself, who I saw as tired and overworked. I perceived both family members in need of help or protection. Thus, I became vigilant to the vulnerability of others, which continues to shape my actions as a caregiver to this day.

Vigilance. Put simply, vigilance is sustained attention over a prolonged period of time, and it has been associated with the ability to detect and react to danger (Hirter & Van Nest, 1995; Warm, Parasuraman, & Matthews, 2008). Driven by individual values, knowledge, and experience, Murray (2017) argues that the standard of vigilance is shaped by a particular (social)

community to which one belongs. These communities set expectations regarding how people should behave in certain domains, thus setting a standard of vigilance required to perform in these domains. As events during childhood have been proposed to influence an unconscious understanding of how to develop social relationships in society, I begin to explore this thread from my childhood stories.

In their study, Luecken and Appelhans (2005) found that early family experiences involving divorce can influence sensitivity to loss in young adults. The authors suggest that a possible explanation for this, may be due to a general sense of vulnerability in these individuals, which has developed from the fear of being abandoned by a parent. Davies, Hentges, and Sturge-Apple (2016) identify four profiles of behavioural strategies that children from families of inter-parental conflict demonstrate, as influenced by psychological processes evolved to neutralize interpersonal threats. The *mobilizing* profile is characterized by a defensive stance, in which children increase their vigilance for opportunities to maintain social ties to the family. Children demonstrating this profile were found to achieve this through "conciliatory forms of involvement" (p. 356), such as caretaking, submissiveness, and ingratiation behaviors.

Working backwards, if my childhood persona of caregiver to my mother was a result of this mobilizing behavior, it would stand to reason that it was an identity acquired from a fear of abandonment once my parents had separated. Psychologically speaking, this could explain why I became vigilant towards recognizing vulnerability, as my brother's vulnerability preceded my mother's attention to him. It is possible that I sought to be useful to her, caring for her as she did for my brother, to prove my value within our new family dynamic. In this way, my childhood self would ensure my mother would have the resources to care for me. Interestingly, this demonstrates what Angel and Vatne (2017) propose regarding the nature of vulnerability, that as a human condition, it invokes a mutual dependency between people to take care of one another.

The authors state, “taking care of others implies taking care of yourself, which maintains the contract that others will take care of you” (p. 1431).

Literature in nursing on vigilance is generally narrow, with a focus on its role in the prevention of error and patient safety (Kooken & Haase, 2014). However, Meyer and Lavin (2005) submit that vigilance is the “essence of caring in nursing” (p. 1), which informs nursing actions. They argue that vigilance is at the core of nursing professionalism, as nurses are trained to identify and attach meaning to clinically significant observations, in order to react and intervene appropriately. Nurses weigh the risks of interventions, in an effort to avoid unintended outcomes, and maintain vigilance by monitoring the results of their professional actions. This awareness and sensitivity to one’s environment not only plays a role in self-governance in a professional context, as it represents the psychological capacity to remain aware of the influence of one’s actions on future consequences (Murray & Vargas, 2018).

As I explore my stories as a nursing student, new graduate, and current practitioner, I notice how vigilance towards vulnerability guides my actions. This could reflect my behaviour as a child, similar in nature to when I readjusted to my new family dynamic. As I adjusted to a new social community (professional nursing), I tried to prove my value by caring for those I perceived as vulnerable, in order to feel a sense of belonging. To further explore this, I identify three aspects of vigilance relating to my perspective of vulnerability, and how it influences my actions as a nurse or professional caregiver.

Recognizing the vulnerability of my patients. As a nursing student, in *Pushing Through Fear*, I am attuned to the vulnerability of my patient by their inability to perform even the most basic personal care need of changing out of a soiled brief. In *The Need to Do My Best by My Patient*, the fact that my patient is non-verbal and dependant on others for care makes her vulnerability obvious to me, in a similar way that my brother was dependant on my mom for his

care. This familiar vulnerability is emphasized in my unconscious mind, which strengthens my resolve to care for my patients. My awareness of their vulnerability triggers a call to action, and my role in their care takes priority in the same way that my mother's vulnerability did to me, when I was a child.

Thorup et al. (2012) argue that nurses' personal experiences with vulnerability and suffering can be important resources, allowing a sensitivity to relate to others in similar contexts. This is demonstrated in *Determined to Support My Patient*, as I recognize the patient with the broken hip and his family as one unit, vulnerable in their silent solidarity, and isolated from outside help. Perhaps, from my own experience as a child vigilant to the needs of my mother, I am especially driven to help, bolstered by a need to prove my value as a member of the nursing profession. These painful life experiences however, may also result in blindness to a patient's vulnerable situation, or a lack of vigilance, if nurses are unable to detach from similar personal experiences (Thorup et al., 2012). Such is the case in the second perspective from my stories.

Failing to see the vulnerability of my patients. Seven years into my practice, the "drama" of a young patient in *Unconditional Care* provoked little sympathy from me. Juxtaposed against the silent family from the ER, I failed to see the vulnerability in this patient, and instead, fixated on other patients on the same unit who were out of sight, imagined to be "also in pain and trying to sleep".

While I grew up learning to become vigilant towards the way my mother displayed vulnerability (silent and isolating), this girl's behaviour was anything but. This could explain why I did not perceive her as such, and as a result, did not feel a need to help her. This lack of acknowledgment towards her vulnerable state would have been emphasized by the response of (what I assumed to be) her mother, who seemed to purposely remain out of sight, despite the

girl's cries. In my childhood, my mother's relentless involvement in my brother's life laid the foundation for my understanding of vulnerability, and those that require care.

In *Learning to Survive*, my perspective of vulnerability, as influenced by my childhood, is further evident, demonstrating the influence of Social Identity Theory. Due to their immature age and increased risk of being harmed or taken advantage of, children are recognized as an especially vulnerable population (Purdy, 2004). Despite this, and arguably due to the vigilance towards my mother's vulnerability (as opposed to my own as a child), I am frustrated in my placement environment where I feel unable to learn how to develop the skills, such as critical thinking, which I prioritize as the job of a nurse. Dominated by a self-imposed responsibility to focus on the needs of those closest to me in my youth, it could be argued that this made it difficult for me to identify, engage in, or even see the value in child-focused activities due to the social environment I grew up in. Originally, my interest to have a placement in post-partum or birthing care could be reminiscent of my experience with a vulnerability I was familiar with, specifically, a focus on mothers as they adapt to a new role of motherhood.

Becoming aware of my vulnerability as a caregiver. In their study, Kaldal, Kristiansen, and Uhrenfeldt (2018) show how Bachelor of Nursing (BN) students experience "a wide range of psychological reactions, such as anxiety, distress and vulnerability during the patient care encounter" (p. 103). Interestingly, as a core component of the nurse-client relationship, empathy, or the "expression of understanding, validating and resonating with the meaning that the health care experience holds for the client" (CNO, 2006, p. 3-4), was shown to make BN students emotionally vulnerable in the clinical environment. By thematically organizing their findings, Kaldal et al. (2018) found that BN students' empathy was influenced by their personal life experiences, and their ability to identify similarities between their close relatives and patients. In

this sense, empathy can be both a positive and negative influence, emphasizing the mutual vulnerability of the nurse-client relationship.

Throughout my stories, empathy is evident in my thoughts, as I strive to do the best by my patients. Like the students in the study, there are multiple instances in which I experience anxiety and a fear of "doing or saying something wrong" (Kaldal, Kristiansen, & Uhrenfeldt, 2018, p. 105). Like the little voice in my head in *On My Own for the First Time*, students were paralyzed by their vulnerability, knowing that they should say or do things in certain situations, but were unable to make decisions due to feelings of uncertainty when their education was inconsistent with the clinical environment.

The story, *Fear and Fatigue,* is a climactic presentation of recognizing my personal vulnerability, as it noticeably impacts my professional identity as a nurse. Whereas before I was able to push past my physical and emotional exhaustion to do the best by my patients, this story demonstrates my vulnerability as Angel and Vatne (2017) describe it - an imbalance between demands and personal resources. Previously driven by a heightened awareness to recognize and address the needs of my patients, as a current practitioner, I am unable to mobilize previous means to suppress *my* needs, which have gone a long time (essentially, since childhood) without recognition.

Further emphasized in my mind by the physical vulnerability of my position as a caregiver, I have become increasingly aware of my personal vulnerability, and thus conflicted by the professional responsibility to my patients. Demonstrated through the nurse's attack at my hospital, research has shown that due to the unforeseeable nature of physical attacks by patients, nurses may work in a constant state of anxiety, which threatens their personal wellbeing (Angel & Vatne, 2017). Despite this, to remain authentic professionals, nurses are expected to be willing

to accept the mutual vulnerability of patient involvement, remain aware of it, and embrace empathy to practice "good" nursing care (Daniel, 1998; Odland et al., 2014; Thorup et al., 2012).

By recognizing my mother's vulnerability, I tried to help her by emulating her role as a caregiver to my brother. From watching her take care of my brother as a child, I learned to recognize what vulnerability looked like, and that sacrifice was required of caregivers (as demonstrated by my mother's constant working and tired look). As a result, this adopted identity as a young caregiver caused me to shun *my* vulnerable role as a child in need of care. Whether consciously or unconsciously, I began to sacrifice my personal needs, shifting the focus from myself to others, as I was socialized to do in this role.

Self-sacrifice. According to Social Identity Theory, the values and beliefs we learn from the social groups we belong to (our socio-cultural environments), play a large role in how we define ourselves. It is these learned values, as well as our past experiences, that predispose us to act as we do in our lives (Rassin, 2008). Interactions between people within socio-cultural groups are guided by social rules, or responsibilities, that dictate how we are expected to act and behave (Gazzaniga, 2018; Ochs & Izquierdo, 2009).

According to Odland et al. (2014), nursing care can be considered a moral practice due to its involvement in human relationships, and patient well-being. By engaging with patients as human beings, taking responsibility as a nurse means treating patients with respect, being present with them, and building trust through the therapeutic nurse-client relationship (CNO, 2006; Gabrielsson, Sävenstedt, & Olsson, 2016). In this sense, personal and professional aspects of nursing are interdependent: not only do they involve interacting with other human beings in the most basic sense, they also demand a responsibility from professionals to facilitate and nurture these relationships in favour of those in their care. For this reason, Gabrielsson, Sävenstedt, and Olsson (2016) argue that the professional responsibility for some nurses greatly weighs on their

moral character. Since the work of nurses has been characterized by a demanding practice environment with demanding tasks, a sense of responsibility can be seen as both a driving force and a burden.

Traditionally nursing was, and continues to be, a mostly female-dominated profession due to the persistent cultural and social values that consider caring to be a feminine practice, and responsibility (Forssén, Carlstedt, & Mörtberg, 2005; Hoeve et. al, 2014; Huppatz, 2010). In part, this is argued to be due to the prevalence of caring in the construction of female identity, a factor that has been commonly identified as an influence by studies exploring the decisions of those choosing to enter the nursing profession, the development of nurses' self-concept, and the construction of professional identity (Dahlke & Stahlke Wall, 2017; Hoeve et al., 2014; Huppatz, 2010).

Caring is central to my understanding of what it means to be a nurse, and how I view myself as a nurse is influenced by my childhood exposure to caring. Although my mother was not a nurse, her intimate role as a female caregiver, as well as my personal identification as a young caregiver from childhood, may have influenced my decision to pursue nursing, as these social roles are very similar. This is supported by the above literature, in that those who chose to pursue the profession identified strongly with a responsibility to care, and associated qualities like empathy, compassion, and altruism.

In the literature, altruism, or a selfless concern for the wellbeing of others, is often discussed as a synonym of self-sacrifice, which has been a familiar theme in nursing since the early twentieth century (Helin & Lindström, 2003; Rassin, 2008; Smith & Lorentzon, 2005). Arguably, it could be said that society has influenced women towards an altruistic role predisposing them to self-sacrifice. Existing literature suggests an asymmetry in the nurse-client relationship, and that the profession of nursing is "founded upon the fact that the responsibility

for providing assistance and care [for patients] is with the nurse" (van Nistelrooij & Leget, 2017, p. 696). Although they are seen as unwarranted or even unprofessional in this modern age, this could explain why sacrificial attitudes and actions are still enacted by carers, despite the shift away from altruism as a previously important value in nursing (Helin & Lindström, 2003; Rassin, 2008).

As much as it still prevails in other carers to this day, this sense of self-sacrifice continues to be evident in my stories as a nurse. In *Pushing Through Fear,* there is clear resignation on my behalf, accepting that my personal needs and desires are secondary to my professional obligations. Despite my nervousness and lack of confidence to perform a nursing task as a student, I attempt to suppress these feelings to complete my task instead. This is triggered by my empathy for the patient, sensing their vulnerable position and wanting to help when the nurse I am shadowing does not.

In Pask's (2005) study, a tendency towards self-sacrifice was uncovered in nurses' narratives, as they continued to act for the good of their patients despite situations complicated by the need to learn, difficulty interacting with team members, and communication within hierarchical structures. As Pask (2005) states, an inclination towards self-sacrifice occurs when we are drawn to act in the interest of something that is valuable to us. In my childhood, this desire seems evident in my dedication to help my mother, who is valuable to me. Now, as a professional caregiver and nurse, this desire to help has become ingrained in my identity: being able to help others has, in itself, become valuable to me.

In *The Need to Do My Best by My Patient*, as a new graduate nurse I am driven to "do my best by my patient" at my own expense. Despite my exhaustion, on top of other work needed to be done prior to shift-change, my patient's needs come first. This suggests what Forssén, Carlstedt and Mörtberg (2005) explore as "compulsive sensitivity" (p. 660), or a strong inner

demand of certain individuals to put the needs of other people ahead of their own. In their study, it was found that some women caregivers experiencing compulsive sensitivity often exerted themselves beyond their capacity, due to the responsibility they felt for others, which resulted in fatigue and ignorance to their own suffering.

Although there is an awareness of my fatigue, I express shame at how long it takes me to recognize that this is "not me". That is, as my needs become too great to ignore, I am disappointed by my inability to ignore them as I did before. According to Angel and Vatne (2017), this shame is commonly expressed by nurses who think they should have done more to reduce their patient's discomfort. In both stories, despite my trepidation to act independently, and with my physical (and mental) exhaustion, I remain focused on the needs of these patients, while ignoring my own.

Once again, the story *Fear and Fatigue* presents a culmination of my young caregiving perspective at odds with the demands of my tasks as an adult, professional caregiver. Despite my awareness of the needs of my patients, meeting these needs no longer provides satisfaction for me, as they are "overshadowed" by more pressing physical needs (the pain in my back, and the hunger in my belly). As one's physical condition becomes perceived as compromised, this can often affect an individual's ability to cope (Angel & Vatne, 2017). In some cases, when people are faced with circumstances that demand more from them, they are able to meet that need in a way that helps them grow. However, when encountering intense demands with limited personal resources, vulnerability occurs based on an individual's personality (Angel & Vatne, 2017; Purdy, 2004; Sellman, 2005).

In my story, my needs become persistent to the point that I no longer take pride in my role as a caregiver, berating myself for this new sense of vulnerability. As a current practitioner, I am even more aware of my inability to dismiss my personal needs, as compared to my

experience as a new graduate nurse, when they became more noticeable. I have become a tired caregiver, just as I observed my mother to be when I was a child, and like her, I never seem to stop working. Despite this, I am still aware of the desire to do my best by my patients, even when I recall past advice from a nurse who cautions me against self-sacrifice as I worry about my patients.

As a nurse and professional caregiver, I feel a responsibility towards my patients which, as Odland et al. (2014) argue, requires actions and decisions that are done for the benefit of those we are responsible for. As a child who took on a caregiving role, my personal moral imperative was founded on being vigilant to the needs of those who are vulnerable, and my family shaped what this looked like. Without correction, I continued to act in the benefit of others as I developed my professional identity as a nurse. Despite the reciprocal nature of my early personal identity as family caregiver and my professional identity, my stories demonstrate a growing imbalance in my ability to sustain this role and to find my sense of belonging.

Belonging

As part of adult identity establishment, individuals actively engage in surrounding social environments with the intention of finding a group in which to belong. As they explore various group alternatives, individuals eventually commit to ones which hold values that are important to them (Galliher et al., 2017; Schwartz et al., 2013). Social Identity Theory emphasizes the process of socialization as the way we seek belonging, which greatly influences the development of both our personal and professional identities. The development of professional identity relies on the internalization of certain values by individuals, as they attempt to fit in, or to be accepted into a profession by its existing members (Cowin, Johnson, Wilson, & Borgese, 2013; Leong & Crossman, 2015; Rasmussen et al., 2018; Zarshenas, Sharif, Molazem, Khayyer, Zare, & Ebadi, 2014). However, existing literature acknowledges that studies of identity development often

overlook these social processes and contextual factors, which can limit our understanding of professional identity formation (Bochatay, 2018; Rasmussen et al., 2018).

Belongingness is an important attribute in nurses' social and professional identities. Having a sense of belonging has been shown to contribute to a positive professional identity, which increases feelings of achievement, job satisfaction, and self-worth (Willetts & Clarke, 2014, Zarshenas et al., 2014). Bochatay (2018) argues that nurses' role performance relies on their identification with the profession's values, and the more they feel a sense of belonging, the stronger their professional identity and their satisfaction with the job. In this way, a person's personal self-concept, or the way they think about themselves, can be closely aligned with their professional self-concept.

As identity development is contingent on finding belonging within society, to more closely examine the reciprocal relationship between my personal and professional identities, I examine the impact of my early experiences with belonging. In this way, I determine how they have shaped my current experiences of belonging to the profession of nursing.

Seeking belonging in my childhood. The following quote by Girard and Grayson (2016) demonstrates the integral relationship between early childhood experiences of belonging, and their influence on subsequent adult development:

> Our earliest relationships of belonging are fundamental for everything we call learning or education. The family provides the individual with his first models: it's by imitating his mother and father that a child learns the basic actions of life. Then come schools, which also provide models without which children would never become adults capable of "functioning" effectively in society. The professional world is another source of learning. Our earliest relationships of belonging secure our social integration. (p. 4).

By deconstructing the experience of socialization in my childhood, I consider how my socialization into nursing has also affected my sense of belonging to the profession. Much like I

sought to belong in my new family dynamic by becoming a caregiver to my mom, my stories suggest that I seek to prove my value through professional caregiving, in order to find belonging as an adult. As Bochatay (2018) suggests, sometimes one's sense of belonging to a profession can be strengthened by the belief that their work is meaningful to others. In fact, positive correlations have been found between individuals who have chosen nursing as a career, and personal tendencies to feel responsible in the care or help of others (Hoeve et al., 2014).

In this self-study, a sense of responsibility to care for my mom, as she cares for my brother, is evident in my childhood stories. This demonstrates what Skorikov and Vondracek (2011) propose, in that we tend to choose our career and work to suit the perception we hold of ourselves. Despite being driven by my childhood notions of what a caregiver is, my stories present disruptions in my understanding of this role. As I practice within the professional world as a nurse, this leads to unsettling experiences that complicate my professional identity development. Later, I face disruptions in my professional role, as I find difficulty settling into a niche of nursing where I feel a sense of belonging.

Identity disruption. For the purpose of this inquiry, identity disruption is examined as an experience of psychological conflict. Identity conflict, as defined by Hirsh and Kang (2016), is "perceived incompatibilities between two or more of an individual's identity domains" (p. 223). In this self-study, these domains are my personal identity, and my professional identity as a nurse. This conflict is believed to emerge when valued identities become equally predominant to an individual, in a way that the expectations of behaviours from each group are opposed to each other. In my stories, there are instances that highlight a disparity between my understanding of a caregiver's role from a personal perspective, and my reality as a nurse. Based on stories of my experience as a nursing student, new graduate, and current practitioner, my professional identity

development becomes challenging, as I am faced with circumstances in the clinical environment that do not align with my personal beliefs and values as a caregiver.

As a nursing student, I am exposed to the reality of the clinical setting in *Pushing Through Fear*. I describe being shocked by the nurse's response, when she says she does not have the time to change the patient out of his wet incontinence brief prior to breakfast. My personal response is empathy, and I am driven to respond to his need, not only from a personal standpoint, but also from my expectation of the responsibilities of a professional caregiver and their care of the vulnerable. This sense of shock is well documented in novice nurses, as they are faced with the reality of the clinical environment, and the inconsistences between what they are taught in school, and the reality of the workplace (Boychuk Duchscher 2009; Ewertsson et al., 2017a; Goodare, 2015; Kramer, 1974; Leong & Crossman, 2015; Maben et al., 2006). Despite this shock, expectations are high that these individuals "should quickly take on their new role and integrate themselves into the realm of nursing practice" (Rasmussen et al., 2018, p. 229). As a result, socialization into the practice environment may require an adjustment of professional identity that differs from one held previously, in an attempt to fit in, and belong (Leong & Crossman, 2015; Odland et al., 2014).

Berkhout, Zaheer, and Remington (2019) mention the effect of "others' gaze" (p. 18) from research in anthropology and psychiatry, in which the perception of being watched plays a crucial role in the construction of self-image. In my story, I view the patient and the visitor as "witnesses", which require me to "act professionally" despite my lack of confidence. This consequence of self-awareness is further described by Conty, George, and Hietanen (2016): "direct gaze perception induces greater sensitivity not only to aspects of the self readily perceived by others but also to private aspects of the self" (p. 186).

For a nursing student seeking belonging in the profession of nursing, the effects of a social gaze are important to consider when exploring how professional identity is formed. Despite evidence from the realm of social psychology that suggests direct gaze enhances self-awareness, activates pro-social behaviors, and results in the positive evaluations of others (Conty George, & Hietanen, 2016), in my story it is met with apprehension and fear. This may be influenced by my strategy as a child-caregiver to stay quiet and out of the way. It would make sense to assume that in this story, my awareness of the attention I perceive would naturally make me nervous, as it is something I actively avoided as a child.

In *On My Own for the First Time,* there are parallels between the disruption in my professional identity, as a nurse faced with the reality of the workplace, and the existing literature. New graduate and student nurses often report a noticeable difference between the professional identity they had developed during their education, and what is required of them as professionals in the practice setting (Odland et al., 2014; Zarshenas et al., 2014).

Despite starting my shift in the structured way I was taught as a student, I quickly find an inconsistency between the time it takes to do thorough patient assessments, and the window of time for safe medication administration. As a novice professional, my panic arises from thinking that as a new graduate, I should know what to do, even though I do not. Previously feeling competent as a professional, I become anxious at this new conflict with my previously-held identity.

Guilt is expressed from my inner thoughts, which insist that I should know what to do, despite my novice position. This guilt could be influenced by a feeling of failing to fit in. As Angel and Vatne (2017) suggest that when a nurse fails to provide proper care, their existence as a "good nurse" (p. 1435) is threatened. When I accept my need for guidance from the charge nurse, I feel shame, and ignore the value I hold for patient care over medication administration at

the expense of her help. Apparently, during professional socialization, it is common for graduate nurses to often forfeit their own values and beliefs when trying to emulate those of the dominant group, just to fit in (Henderson, 2002; Odland et al., 2014).

While newly educated nurses struggle to exhibit care values and ideals from their education into the workplace, they can find that performing the tasks and duties required of them often takes all of their energy (Odland et al., 2014). In *The Need to Do My Best by My Patient*, this is evident in the physical and emotional exhaustion I express, as I work my eight-hour shift as a new graduate. Nearing shift change, this state of exhaustion causes a shift in my desire to act in the best interests of my patient, and I contemplate leaving her to be changed by the staff from the next shift. Previously, I rationalized from the knowledge I learned in school, that having C. Difficile puts patients at high risk for skin breakdown, which requires vigilance to keep skin dry and clean. By the end of my shift, I acknowledge the conflict between workplace demands and my personal and professional desire to do the best by my patient through providing knowledgeable, efficient care. In this instance, my sense of accountability as a person and a professional is weakened by the demands of my environment, and I do not recognize myself.

Pask (2005) identifies this "disengagement from [the] self" (p. 252) as a coping mechanism of nurses who find themselves in situations where they are unable to fulfill their sense of responsibility. In this state, I hover between two identities, either compromising my personal needs in order to fulfill my accountability as a professional, or prioritizing my own interests over the care of a patient. Wrzesniewski and Dutton (2001) argue that identity is not something that can be changed at will, and that part of the social identity that individuals create at work is based on who they see themselves as, and why what they do matters to them. By making the decision to change my patient at the end of this story, I act in a way that holds

meaning for me as an individual, demonstrating how my personal and professional identities are mutually informing.

Despite the resurfacing of increasing demands from the environment, the determination to act in the best interests of my patients does not seem to be as evident in my story *Fear and Fatigue*. The conflict between my two identity domains in this story is magnified, not only by the culmination of more specific physical needs (hunger in my belly, pain in my back), but by a sense of personal defeat, in which I admit that the rewards of helping are "easily overshadowed" by these needs. This is in direct contrast to my actions in *Determined to Support My Patient*, where I am proud of my efforts to help a patient in pain, despite not knowing if they were effective. Whereas, before in my stories my tendency towards self-sacrifice is evident, here it is challenged. Since my notions of what it means to be a caregiver were heavily influenced by this pillar developed from childhood, this conflict highlights a disruption at the core of my identity (both personal and professional), which usually put the needs of others ahead of my own.

Hirsh and Kang (2016) argue that personal identity conflict will result when the idealized standards of behaviours for a group become incompatible with self-standards and personal norms. As evidenced by my psychological distress in this story, my personal needs have become increasingly noticeable as a current practitioner, when compared to my stories as a nursing student and new graduate. In a sense, they have become too great to supress, demonstrating the authors' assertion that "as the number of salient social identities increases, so too does the chance of experiencing heightened behavioral conflict and uncertainty" (p. 224). Leong and Crossman (2015) note that misaligned personal and professional identities become apparent in nurses for a variety of reasons, and at all levels of practice concerning procedures, values and behaviours, as well as from interpersonal tensions between colleagues. It is also common for negative environmental conditions, such as demanding workloads, to contribute to this conflict, as was the

case in my story when I ruminate on all the tasks I need to complete. When this occurs, the likelihood of successful transition and retention into the profession or an organization diminishes, as well as the sense of belonging (Leong & Crossman, 2015).

Since identities are developed based on the influence of the social groups we belong to, it is common for individuals to "self-stereotype" (Hirsh & Kang, 2016, p. 224), or behave in a way that is reciprocal to the normative standards of those groups. As a child seeking to act as caregiver to my mom, I developed similar behaviors in order to mimic her role as caregiver to my brother, and subsequently carried them into my practice as a nurse. Ironically, the second thread in this pattern of belonging, *isolation,* is paradoxical, as it could contribute to the identity conflict expressed in some of my stories. To explore the effect this has on the current inquiry puzzle, I explore this second thread more deeply.

Isolation. In the world of nursing, isolation most often refers to infection control practices in the clinical environment designed to mitigate the risk of contamination, and is designed with the safety of nurses, patients, and the general public in mind. Despite the singular mention of a patient on isolation in *The Need to Do My Best by My Patient*, for the purposes of this inquiry, isolation is used in reference to a physical and/or mental separateness (intentional or otherwise) from interactions outside of a familiar social group. In this self-study, I demonstrate how my personal identity is molded from childhood by the social interactions of my family, and how these have continued to influence my identity throughout my career as a nurse.

Moving backwards from the present, in *Discord in My World* the separation I feel from my mother is palpable, almost like an outsider looking in to see how relentlessly she works to care for my brother and me. Despite my perception of her exhaustion, I do not see her stop working, and assume that as her second child, she would also feel an obligation towards me.

According to a study by Nixon, Greene, and Hogan (2012), the majority of children growing up in a single parent household were, at the time, "cognizant of their mother's workload, stress level, and limitations in her capacity to address their needs" (p. 149). Wallerstein (2005) argues that children grow up more quickly in divorced families, and that this is a natural result of their efforts to understand the events that led to their situations. Although Erikson's theory (1963, 1968) associates the period of early adulthood, or adolescence (at about 12 to 18 years old), with the beginning of identity formation, this demonstrates how children from divorced families may enter this stage sooner.

As demonstrated by my seven-year old self in *Helping Mom*, despite acknowledging that, at my young age, I do not know how to help her, it is here that I make a conscious decision to take control of my needs. By choosing to act in a caregiving role previously reserved for my mother, my actions demonstrate how, as Wallerstein (2005) argues, children in divorced families may develop a more persistent personal identity due to the early influence of their immediate social environment (family). In my case, this became my caregiver identity that follows me from my childhood into my adulthood, and into my professional role.

Children growing up in divorced families demonstrate more independent thinking, as they are often required to take responsibility for themselves and/or their siblings (Wallerstein, 2005). Aware of their mother's isolated parenting role, the children are found to modify their behaviour in a way that reduces the demands they place on their mothers, to avoid worrying them or making them upset. They also worry about their parents' wellbeing and are driven to take care of them, in an effort to ease their perceived suffering.

As I saw my mother in her solo parenting role, providing care to my brother and me, my childhood-self desired to take care of her. Like other children from divorced families in the literature, to reduce the demands I placed on my mother, I isolated and put aside my needs. By

choosing to stay quiet and out of her way, I assumed responsibility for myself in a way that achieved this goal, as she later admits that she has never had to worry about me. By witnessing how my mother, in a single-parent role, put her children's needs ahead of her own, I as a child, perceived her independence as isolation. Through this, I assumed that a caregiver is personally accountable for the care they provide, separate from others to share in the task, and that the needs of others come before my own.

A personal acceptance of isolation in my caregiving is evident in a number of my stories, as I demonstrate an avoidance of asking for help in my roles as a student nurse, new graduate, and current practitioner. Despite my initiative as a nursing student in *Pushing Through Fear*, there is palpable relief when I think the nurse I am shadowing has returned to help me change a patient's incontinence brief. However, I am left to complete the task without supervision despite my uncertainty, and instead of seeking help, I accept the task without it. This demonstrates how preceptors and clinical facilitators have been shown to play a key role in socializing nurses into the professional environment, influencing the skills, knowledge, behaviours, and attitudes that are internalized by novice practitioners (Ewertsson et al., 2017b; Goodare, 2015; Henderson, 2002; Odland et al., 2014).

Strong evidence suggests that interactions with mentors and peers shape nurses' professional identities, which can influence a sense of belonging that individuals develop with the profession (Goodare, 2015; Zarshenas et al., 2014). However, it is not uncommon for students to report feeling marginalized, alienated, and excluded in the social environment of the clinical setting (Rush et al., 2009). What students do or see in clinical settings, in addition to what they experience through their personal life events, including education, shapes their idea of what a professional nurse is and does (Ewertsson et al., 2017b; Zarshenas et al., 2014). Likewise,

it is possible to interpret that through my early childhood experiences, I come to understand my professional role as one that practices in isolation from colleagues.

As a new graduate nurse in my story, *On My Own for the First Time*, I am excited to have my independent assignment, which may be influenced by my earlier childhood experience with independence and accepting responsibility as a caregiver to my mother. However, as my shift progresses, I soon find that, despite practicing as I was taught in nursing school, I am easily overwhelmed by the work. This is not uncommon, as Benner (1984/2001) states that even with a high level of competence as a novice nurse, learning the level of responsibility required to work as a professional can be overwhelming. In the stories of newly educated nurses who possess a strong sense of responsibility (having practiced for a period of up to 16 months), individuals find themselves unprepared and shocked by the requirements of their roles (Odland et al., 2014). Despite my novice position, my inner thoughts insist that I should know what to do, and when I seek the help of the charge nurse, I experience a sense of shame from my failure to act without help. From this point forward, even though I disagreed with the charge nurse's priorities, I accepted that I was unable to act alone. The previous confidence I held in my identity as an independent nurse, became stifled in order for me to successfully, and in a timely manner, meet the expectations of my environment.

In my second story as a new graduate, *The Need to Do My Best by My Patient* explains my involvement with a patient in isolation with C. Difficile. Despite my exhaustion, I am unable to ignore the care needs of my patient or leave them to the next nursing shift. This continues to demonstrate high personal expectations of myself, and feelings of sole responsibility in my professional life. Naturally, these behaviours manifest in secluding ways, such as a tendency to avoid asking for help from colleagues. As a result, I am left with the feeling that I am indeed on my own, and that I must do everything by myself to prove my value, and to belong as a nurse.

The story, *Fear and Fatigue,* culminates my thoughts as a current healthcare provider practicing in isolation. Being a float nurse, in itself, denotes the feeling of being an outsider: despite being an employee of the hospital, there is no central unit where I am located, where I belong. Straw (2018) validates this and highlights that unit-specific practices (i.e. initiatives, staff recognition, awards) can inadvertently isolate float nurses, contributing to their perception as temporary staff, rather than valued members of the care team. Despite conversations of the nurses around me regarding the attack on a nurse, my monologue turns noticeably inwards, highlighting an imbalance between my personal and professional abilities, and an assumption that I have sole responsibility for tasks. If I had been more integrated in relationships with other nurses, it is possible that I may not be feeling such a heavy weight on my shoulders, demonstrating Wrzesniewski and Dutton's (2001) argument that "interactions with others help employees define and bound tasks by shaping impressions of what is and is not part of the job" (p.179).

Working as a float nurse may also emphasize the isolation I express in my practice. Whether I was drawn to the position by the isolation it allows, which is familiar to me, or whether it contributes to my lack of satisfaction within the nursing profession, is unclear. Wrzesniewski and Dutton (2001) propose that individuals craft their jobs, and ultimately their work identities, through the tasks and interactions that they are involved with on a continuous basis. They define job crafting as "the physical and cognitive changes individuals make in the task or relational boundaries of their work" (p.179). They propose that from the need for human connection, human beings are motivated to find meaning in their lives by forming connections with others. Since individuals find meaning in belonging to social groups that they value (Bochatay, 2018), the relationships that individuals form at work can also influence the meaning that their work holds in their lives.

As previously mentioned, when a person experiences a conflict between salient identities, a mental segregation strategy usually results to prioritize or compartmentalize them to avoid conflict (Hirsh & Kang, 2016). In instances where they cannot be kept completely separate, this strategy becomes ineffective leading to "profound psychological tension" (p. 225). Because my identity as a person is reciprocal to my professional identity as a nurse, I cannot reduce the conflict between them by prioritizing one over the other. Instead, my strategies have been to supress, or avoid, the needs of one for the sake of the other. When segregated identities eventually emerge despite these attempts, these conflicts tend to become even more stressful than before (Hirsh & Kang, 2016). This is the case I now face between my childhood perception of a caregiver, and the influence of my current clinical environment on my identity as a professional caregiver, and nurse.

In Summary of the Second Stage of Analysis

In the second level of analysis, the practical justification, I engaged, as my inquirer-self, more deeply with my told and lived stories. I accessed scholarly literature to gain a deeper understanding of my inquiry puzzle. From my stories I identified two narrative patterns, *vulnerability* and *belonging*. Following, I examined the threads of *vigilance* and *self-sacrifice*, and *identity disruption* and *isolation* within their respective patterns, to identify and explore the reciprocal relationship of my personal and professional identities.

Using the three-dimensional space of Narrative Inquiry, I explored how my childhood experience as a young caregiver to my mother has influenced (and continues to influence) my understanding of what it means to be a professional caregiver, a nurse, today. To do this, I applied temporality by moving backwards through my early childhood experiences, to my student nurse experiences, and forwards, to more current ones as a practicing professional. By looking outwards at the environmental situations and social conditions I belong to, along the

continuum of my lived experiences (growing up in a divorced household), I simultaneously reflected inwards to closely examine the personal values, beliefs, and morals behind my actions.

Using Social Identity Theory as a lens through which I examined my inquiry puzzle, I explored in depth the social environment, considering the interactions and relationships, which impacted my lived experiences. In turn, I identified how these interactions shaped my concept of what it means it be a caregiver, in both a personal and professional sense. By exploring the places in which these experiences occurred (my childhood home, clinical placements, the hospital I work at), I examined the impact of my environment on my thoughts and feelings, which ultimately shape the way I continue to live my stories today.

Making Sense of my Lived and Told Stories

Through this self-study, I took the opportunity to understand first-hand, how our lived experiences shape subsequent experiences, and how these in turn shape our lives. Through the theoretical lens of Social Identity Theory, I dove into the psychosocial underpinnings of identity development to recognize how identity formation, both personal and professional, is greatly influenced by the social environment we grow up in. By doing this, I was able to acknowledge my interdependence with others in a way I was previously unable to do.

Prior to engaging in my inquiry puzzle, I believed that my parents' divorce was simply part of my past. Although I hold no negative feelings towards my parents and their decision to separate, I am shocked to discover how this experience has influenced my life up until now. By engaging in intentional critical reflection, my childhood experiences became educative. I came face-to-face with a vulnerability I have been supressing for years, without even knowing how or why. As I imagine this habit will not be easily unlearned, engaging in my self-inquiry has expanded my options on how to proceed into the future.

My exploration sheds light on the current imbalance between my personal and

professional desires. Behind my actions, I uncovered a desire for human connection, and the need to belong, which ironically, I have been unconsciously working against, through self-imposed isolation, and ignorance. Scrutinizing the threads of my narrative patterns, I note that I have not only alienated myself from those in my personal and professional life, I have also become isolated from *myself*. Over the years, I have supressed my own needs, thus diminishing my own ability to thrive as a person and a professional.

Throughout this inquiry journey, I have come to more fully understand myself: the personal value I hold in helping others, and the decision I made early in life to become a caregiver to fulfill this desire. By bringing these discoveries to light through reflective process inherent in Narrative Inquiry, I have been able to identify the dissonance between my personal and professional identities, as I am faced with challenges within the workplace. By re-creating meaning from these experiences, I have developed a renewed consciousness of myself as a person, including how I have been shaped by my experiences from childhood, nursing school, and my present work conditions. With this knowledge I move forward and live my truth guided by the values that inform what kind of person, and nurse, I want to be.

Looking Back – Looking Forward

In this chapter, I engaged in practical justification, the second level of analysis in Narrative Inquiry. I identified narrative threads that emerged from my stories, and explored how they joined to create two narrative patterns (vulnerability and belonging). Using Social Identity Theory as a theoretical lens, I incorporated relevant scholarly literature to explore how personal and professional (nursing) identities develop, in order to understand their reciprocal nature, thus informing my inquiry puzzle.

In the next chapter, I engage in social justification, the third level of analysis, where I explore the relevance this inquiry may have to society at large. I also consider its significance for future nursing practice, research, and education.

CHAPTER SIX

Social Justification

In this chapter, I engage in the third level of analysis in Narrative Inquiry, known as social justification. As I continue to expand my understanding of how my personal and professional identities are mutually informing, I now consider the possible significance of my learning to identity development, the nursing profession and to the greater society.

By revisiting the narrative patterns that I uncovered in the practical justification chapter, vulnerability and belonging, I critically analyze their relevance to my inquiry puzzle. In that light, I briefly discuss *practice readiness* of new nursing graduates and consider the importance of personal and educational factors that contribute to this. Next, I discuss *personal knowing* as it relates to knowing self, as opposed to knowing about oneself (Chinn & Kramer, 2015). I re-introduce the existence of mutual vulnerability between nurses and patients, highlighting how self-reflection can identify opportunities for growth in these relationships. Following, I discuss the implications for self-reflection and personal knowing as they shape future learning opportunities for nurses. Lastly, I consider the significance of this inquiry to research in disciplines beyond nursing.

Significance for Education

Mirza, Manankil-Rankin, Prentice, Hagerman, and Draenos (2019) acknowledge a scarcity of literature focusing on humanistic characteristics (compassion, relationality, and openness to vulnerability) essential for providing quality care in the context of practice readiness for new nursing graduates. Generally, what it means to be *practice ready,* or prepared to take on a nursing role, is not well defined in current literature (Mirza et al., 2019). There is a shared responsibility between academic educators and practice partners within the current clinical environment to prepare nurses for the transition to practice. Although it is important to ensure

new graduates are competent in their practice capabilities (clinical assessment, critical-thinking, and problem-solving skills), it is equally important to promote their growth as authentic, compassionate practitioners (Mirza et al., 2019). As academic institutions help students develop capabilities for their future professional roles, they are also in a position to support their socialization into the profession. These, often called soft skills, are intended to foster positive professional identity development, which is meant to sustain an alignment between students' personal and professional values in challenging situations.

Just as professional nursing involves taking on multifaceted roles, nurses' identities are informed by various personal roles, thus enlightening each other. As demonstrated by Social Identity Theory, our behaviours as individuals are heavily influenced by the social groups to which we seek to belong. Generally, the stronger an individual identifies with a (social) group, the more the group influences their values and behaviours (Hirsh & Kang, 2016; Knez, 2016; Willetts & Clarke, 2014). As nurses, we also exist outside of our profession. We are persons from varying backgrounds with different levels of life experience. As persons, we are relational beings, and are often socialized to belong to many groups over our lifetime. For example, a nurse can identify as teacher, parent, offspring, and sibling amongst other social roles simultaneously, and although one identity may be more salient at a particular time, they all intersect to form the nurse's existence as an individual and a professional. In this way, our personal and professional identities are mutually informing. Just as Dewey's philosophy proposes that "our experiences are developed from other experiences, and that earlier experiences lead to further experiences" (Clandinin & Connelly, 2000, p. 2), our early concept of self is a prerequisite for the development of future personal and professional identities.

As caregivers charged with the safekeeping of sick individuals, nurses are often encouraged to perform *patient-centered care* by implementing individualized, holistic care

strategies, which are specific to each patient's context (Schwind et al., 2014). However, it has been suggested that an attribute of such care, relies on the ability of nurses to possess a degree of self-knowledge, which includes clarifying their personal beliefs and values (McCormack & McCance, 2006).

For the above reasons, it would be invaluable to incorporate more holistically *personal knowing* into nursing education of students and professional development of practicing nurses. Based on my study, and other scholarly literature I accessed through this process, I would recommend that nursing education extend its curriculum beyond cognitive learning to also include experiential approaches, where nursing students engage in activities that develop personal knowing. For practicing nurses, this could be achieved through supported experiential workshops in their place of work.

Personal Knowing

Carper's (1978/1999) *Patterns of Knowing* represents reflection on nursing practice, which has the potential to bring awareness to the unique reality of an individual practitioner. As Chinn and Kramer (2015) state, "it is knowing the Self that makes the therapeutic use of the Self in nursing practice possible" (p. 9). The *Self* then becomes a concept in Carper's personal knowing, imposing a non-objective point of view that sees the individual practitioner as whole, aware, and genuine. Through a process of "questioning, acknowledging, and understanding such factors as personal biases, strengths and weaknesses of character, feelings, values, and attitudes" (p. 9), becoming an authentic practitioner enables a more meaningful construction of the therapeutic relationship between nurse and client.

When caregivers engage in self-reflection of this nature, they are able to become more present in the care of their patients (Chan, 2008; Schwind et al., 2014). By being present with their patient(s), and by being aware that how they provide care is informed by their previous life

experiences, nurses have a greater opportunity to engage in more genuine and authentic therapeutic relationships (J. Schwind, personal communication, August 14, 2019).

Self-Reflection: Recognizing Vulnerability as an Opportunity for Growth

As stated by Sasha, Lindsay's (2008) co-participant:

> Self-reflection forces you to bring to the surface things that are dormant, and if you address them, you grow as a person. You recognize things that need to change, things that are right for you, even why your actions are the way they are. (p. 28).

Unfortunately, the current health care environment offers contexts ripe with difficulties for nurses, both novice and experienced alike. Nurses are often positioned within situations of conflicting demands that are both internal (personal values and beliefs, the socialization to follow orders) and external (policies, institutional rules, interprofessional relationships) (Hem, Halvorsen, & Nortvedt, 2014; Hoeve et al., 2013; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004; Wilkinson, 1987). This highlights the existence of a mutual vulnerability between patients and nurses, as seen in my stories *The Need to Do My Best by My Patient*, *On My Own for the First Time*, and *Fear and Fatigue*. The extent to which these issues contribute to the vulnerability of nurses within the current clinical environment is a valuable avenue to consider in future research.

As patients exist in a vulnerable state, they deliver themselves into the trust of nurses, which demands professional care (Thorup et al., 2012). However, as human beings, both patients and nurses are vulnerable in the way that van Nistelrooij and Leget (2017) argue, that "human interdependence and vulnerability are core traits of human existence" (p. 695). By recognizing this mutual vulnerability through self-reflection and personal knowing, nurses are able to make the conscious decision to participate in a relationship with their patients as authentic practitioners. With caring as its central premise, the courage to help patients while facing their

own vulnerabilities as care-providers requires courage, but has far-reaching benefits as a vehicle for personal and professional growth (Angel & Vatne, 2017; Daniel, 1998; Thorup et al., 2012). In the words of Daniel (1998), "if we deny the opportunity to participate in vulnerability, we deny the opportunity to participate in humanness" (p. 191). By participating in reflective practices, nurses are able to more easily access their sense of being a complete human being, which allows them to relate to other people, extending compassionate care to themselves and those in their care.

Using creative methods of self-expression through story-telling or artistic creations (arts-informed approaches), nurses are able to access deeper meaning from experiences that may not be initially obvious to them (Walji-Jivraj & Schwind, 2017). As one such approach, the *Narrative Reflective Process* (Schwind, 2008, 2016; Schwind et al., 2012) has been used to elicit the personal and professional growth of nursing students, teachers, and practitioners alike, facilitating reflection on professional and therapeutic relationships, as well as their identities as caregivers (Lindsay & Schwind, 2015; Schwind, Santa-Mina, Metersky, & Patterson, 2015; Walji-Jivraj & Schwind, 2017).

As Kent (2008) notes, "writing and telling stories of the tensions and vulnerability in practice situations provides multiple field texts to unravel the puzzles in the complex human experiences of caring, learning and identity emerging in relationships within practice" (p. 55). If nurses continue to distance themselves from the increasing physical and emotional stress of the health care environment, inevitably, this will affect patient care. Because of the reciprocal nature of personal and professional identities, nurses' psychological states will affect the care they provide, and their ability to engage with patients. As Kramer (1974) observes, "A nurse who is severely at conflict and unhappy will experience difficulty in effecting the climate and relationship with her client that is most conducive to his well-being" (p. 219).

As a deeply humanistic profession, it is therefore beneficial for practitioners to reflect on the mutually informing nature of their personal and professional identities, as persons, and nurses. Through self-reflection and personal knowing, nurses can gain a better understanding of the experiences that made them who they are today, thereby becoming more holistic, compassionate, and knowledgeable professionals. Lindsay (2008) notes, "…who you are and what you bring to a nursing situation informs how you will behave as a nurse" (p.29), demonstrating her assertion that who we are as persons, is who we are as professionals (nurses).

Implications for Nursing Practice

As the effectiveness of coping strategies diminishes, nurses are vulnerable to burnout, compassion fatigue, moral distress, and accompanying physical manifestations which contribute to higher turnover within the profession (Alarcon, 2011; Li, Guan, Chang, & Zhang, 2014; Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, & Smith-MacDonald, 2017; Wilkinson, 1987). As Chan (2008) notes, by exploring the experiences of her new graduate nursing students, a sense of unease surfaced when they recognized how, in their everyday coping and nursing activities, a loss of a caring attitude was prevalent. Through continued learning and forging support networks with each other, Chan's students were able to stop and reflect on experiences that challenged their caring experiences as students and registered nurses. As reflected through the process of Narrative Inquiry and Dewey's philosophy of experience, by restructuring our experiences, we are able to develop a basis of knowing that underpins what we do (Lindsay, 2008). By bringing this knowing into the present, this offers an invaluable opportunity to empower nurses to be the kind of professionals that they want to be.

As Schwind notes (J. Schwind, personal communication, August 14, 2019), when nurses struggle with identity, they become disenfranchised and struggle with belonging. By using creative strategies, such as narrative and arts-informed approaches for self-reflection, nurses can

develop personal knowing to critically reflect on their lived experiences to better understand the connection of how personal and professional selves are intimately related (Schwind et al., 2014). From this, nurses can learn how to recognize the contextual and interactive nature of their practice, in order to reconstruct new meaning that will support their sense of belonging in the profession. When we are better able to understand ourselves, we are more likely to engage in relational nursing practice, which acknowledges our role as "an instrument of care" (Schwind, Cameron, Franks, Graham, & Robinson, 2012, p. 1) that can most efficiently benefit our patients, and society as a whole (Hem et al., 2014).

Gustafsson, et al. (2007) highlight reflection in nursing as *caring science learning*, which acknowledges the practice of caring as an art, and the importance of its development to improve the quality of patient care. Reflective practice enables learning, both personal and professional, which illuminates the clinical environment and the potential it allows for caring, as nurses practice reflexivity and develop themselves as caregivers (Börjesson, Cedersund, & Bengtsson, 2015; Eaton, 2016; Gustafsson, et al. 2007).

Considering Future Research

By exploring nuances of identity development and relating mechanisms of adult identity establishment through my inquiry puzzle, I highlight how the interactions we have with others in our personal and professional social environment, influence our understanding of who we are and what we, as nurses, bring into our therapeutic relationships with patients. Because of this, I imagine that my stories, and subsequent exploration of emergent narrative patterns, may be transferable to other disciplines outside of nursing, including psychology, philosophy, social and behavioural sciences, education, and potentially, management and organizational practices.

Looking Back – Looking Forward

In this chapter, I engaged in social justification, the third level of analysis in Narrative Inquiry. I explored the relevance that my inquiry may have to society, by considering its significance for future nursing education, practice, and research. I addressed the questions "So what?" and "Who cares?" by exploring the significance that this inquiry may contribute to deeper understanding of identity development and professional socialization in the context of nursing, and its relation to the care of patients, as members of greater society. In the next chapter, I re-present the reconstructed in form of a letter to new nursing graduates.

CHAPTER SEVEN

Narrative Re-Presentation

In this chapter, I gather what I have learned from deconstructing my stories of experience in previous chapters and reconstruct an expanded understanding about my inquiry puzzle. With the insight I gained into the reciprocal relationship of my personal and professional identities, I now write a letter to the new nursing graduates. I direct this letter to novice nurses, to express to them the value of engaging in critical self-reflection, using the Narrative Inquiry qualitative research approach (Connelly & Clandinin, 1990; 2006). I strive to convey how intentional self-reflection (Dewey, 1938/1997) is a tool for personal and professional development and learning, creating greater options for future ways of practicing nursing. I believe that such an activity may support a greater sense of wellbeing of nurses, especially when they experience stress, and are overwhelmed in their professional roles.

Dear New Nursing Graduates,

Congratulations! I am sure you worked hard to get where you are now, and you should be proud of your accomplishment. When I graduated, it felt very surreal to have reached the end of my formal schooling, to have written my licensure examination, and to finally be able to call myself a Registered Nurse. I imagine you are feeling all kinds of emotions, so take a moment to recognize and acknowledge them all. Being able to do this is an important practice you should not soon forget.

This is the beginning of a journey for you, and as your education did, it will challenge you. Do you remember how you felt when you were a nursing student entering your clinical placements for the first time? There were probably a lot of inconsistencies between what you were being taught in school, and what you were seeing in your clinical placements. You may have seen some short-cuts being practiced, which didn't sit well with you, and you may have been afraid to speak up. You probably had mixed reactions of awe and disgust with the things you saw, which could have excited you, or made you wonder what you were getting yourself into. I certainly did. You might have had a chance

to experience a type of nursing that you immediately disliked, or you may have immediately felt like you fit in a particular environment and are excited to find a way back to it.

A lot of research has been done to explore the experiences that you and countless others, including myself, have had during their time as a nursing student. This type of research continues to be done in order to explore new and more effective ways to prepare and support students for their professional work environment. However, as I'm sure you may be aware, it would be impossible for school to be able to prepare you for everything you will see, or everything you will encounter as you practice as a nurse.

I had an anxiety attack the first day I practiced on my own with a full nursing assignment, outside the shadow of a preceptor. I was incredibly embarrassed, even though I believed I was doing as I was taught in my nursing program. I felt enormous guilt, not knowing what to do, and felt that I should have known. Luckily, I was able to get help from a colleague, but not without feeling that I was a burden. In fact, I felt like I did not belong, and wondered what I was doing in nursing.

Over the years I practiced, I had always been consciously aware of the vulnerabilities of my patients, and my responsibility as a care-provider to them. It wasn't until recently, however, that I began to recognize my own vulnerabilities as a person, and a nurse. I want you to know that it took years for this to surface, even though all the signs were there. In this profession we often suppress our own needs – a need to sit, a need to eat, and even a need to use the bathroom – in order to get the job done. This all builds up over time, and the unheeded anxiety grows.

If there is anything I could impress upon you, it is to learn how you have come to be where you are. There are many factors, conscious and unconscious, that have influenced who you are today. We gather our experiences through the interactions we have with others in every aspect of our lives. We are guided by our personal values, morals, and desires. For me, I knew from a young age that I wanted to help people, but it wasn't until now that, through deep self-reflection, I learned this was driven by my desire to belong. This desire was so great that it has followed me throughout my life, and played a large role in my tendency to suppress my own needs. In nursing, the needs of my

patients were so imposing, that I often overlooked my physical, mental, and emotional wellbeing.

From your nursing education, you may recall Carper's *Patterns of Knowing* (1978/1999), which proposes how nursing praxis embodies four ways, or patterns, of knowing. Carper presents personal knowing as having knowledge of (your)self, and argues that to be an authentic practitioner, we should learn to understand our personal biases, strengths, weaknesses, feelings, and values. As we learn to know ourselves through this introspective process, we learn to grow as persons and professionals. We learn that who we are as persons is who we are as professionals. By recognizing this interconnectedness, we gain a better understanding of how we practice nursing.

As you identify with various groups in your personal life (daughter/son, nurse, mother/father, teacher, community member etc.), all these identities intersect to make you who you are as a whole human being. Work is another part of your identity, and who you are as a person, reflects who you are as a nurse (Lindsay, 2008). Learning to know yourself is a powerful tool that can help you in all aspects of your life. However, as a nurse, the more you know yourself, the more you can engage in authentic, compassionate relationships with your patients. By bringing this awareness of self into the therapeutic relationships, you are bringing your humanity to those in your care, to support them in their most vulnerable moments. They are counting on you!

As you move forward in your career, don't be afraid to acknowledge when you are going through a difficult time, you are only human after all, as we all are. There can be no care for patients, if there is no care for ourselves as nurses. Reach out to colleagues and others you trust. Just as you engage in a partnership with your patients, engage in relationships with your colleges to enhance your sense of belonging. Speaking from experience, although you may feel that being able to work on your own is necessary to be personally accountable, self-imposed isolation makes it harder to recover from a dark place. Seeking help does not make you weak, or any less of a professional. In fact, it strengthens your value as a care-provider, proving you have courage to face your vulnerabilities, in the same way you can empower your patients to increase their capabilities.

Through self-reflection you can deconstruct your life experiences, and not only gain a deeper insight into the context of the environment around you and its influence, but also gain self-knowledge. Through my experience, not only did I gain insight into the circumstances that led me to this point in my life, I also gained a deeper appreciation for the impact that my relationships with others had, and continue to have, on me. This has allowed me to appreciate that the patients I care for, have also become who they are from interactions throughout their lives. Through this process, I have come to recognize my own and my patients' humanity.

By learning about myself as a person, through this practice, I have re-acquainted myself with the professional I wanted to become when I first decided to pursue nursing. Although this may not seem like such a long time ago for you, my hope is that you take time to know yourself to appreciate your own needs as they surface throughout your nursing practice. Remember that our lives are touched by those around us, and we are all in this together.

In Solidarity,
Your Fellow Nurse
Christina Di Stasi

Looking Back – Looking Forward

In this chapter, I reconstructed my stories of experience from the previous chapters of analysis, to write a letter to new graduate nurses. Using the insight I gained by exploring my inquiry puzzle, I conveyed the value of self-reflection. I also explored the use of personal knowing in nursing and expressed how this is a helpful tool to guide personal and professional development.

From here, I move to the epilogue and reflect on my journey through the process of self-study, using Narrative Inquiry.

EPILOGUE

The work day has already started, and I am working on the orthopedic surgery unit again. After assessing my group of patients, I have just finished giving out all their morning medications, when the charge nurse on the unit approaches me.

"I just got a call from your manager. She needs you to go to surgery to pick up an assignment for a nurse who is going home sick."

As I stand facing her, I try to process what she has said. I am shocked that I would be moved to a different unit at this time in the day, but I am also disappointed. My assignment is reasonable, made up of patients with medical diagnoses, which I am most familiar with, as opposed to recent surgical issues that can be quite intimidating for me. I was hopeful it was going to be a good day today, but now I am not so sure. Unfortunately, this is what I have chosen as a float nurse.

On the surgery unit, I am receiving report from a covering nurse about my new group of patients for the day. One of them, it sounds like, is going to be challenging.

"She is just miserable*. She's been refusing to get out of bed for days, and just wants to be left alone" the nurse tells me.*

As I push aside one of the bedside curtains in a ward room, I see a small, elderly lady laying in the middle of the hospital bed with her eyes closed. I raise my voice in a greeting, slowly rolling a vital sign machine behind me, and I introduce myself to tell her I am going to be her nurse for the rest of the day. The lady opens her eyes and frowns, but allows me to do my assessment.

"How are you feeling?" I say.

"Exhausted. They tried to get me up in the chair but I just want to sleep. I haven't been able to sleep since I got here two weeks ago".

I decide to leave her be, and check to see that she has her call button beside her, before I go.

"Let me know if you need anything" I say, closing the curtain behind me in the way she insists.

I keep checking on her throughout the day, careful to avoid bothering her any more than necessary. Soon, she is calling me to help her use the bedside commode. Helping her out of bed, I see that she has a pair of shoes that have been stitched up, and well-worn. I make a comment about this, and she smiles.

"Those are the best pair of shoes I've ever had" she is telling me, engaging in a story about the shoes' origin. Soon, she starts talking about her five children, and as I gently cue her to the commode, I am listening attentively.

As I am about the leave the room, one of the other patients in the room waves her hand to get my attention. This lady is also one of my patients for the day.

"I've been here two days and that is the most I've ever heard that lady talk" she says to me, referring to her neighbor, "I thought she was dead!"

I try not to laugh, but let out a small snort. She nods her head.

"You have something special" she says to me.

* * *

Feeling like a metaphorical cog, ever turning in the great machine of health care, I began this journey screeching under pressure. As I know the whole machine relies on each individual gear, when I set out on this exploratory journey, I wondered, *Does anyone hear the nurses wearing down under the strain of this ever-challenging environment? How can I continue to produce for this machine, constantly in the service of others, when I feel like my own needs aren't being met?*

By exploring these feelings throughout this journey, I recognize a disruption between my personal and professional identity, and seek to address it, through a rediscovering of meaning in my work as a nurse. Using the temporal space of Narrative Inquiry, I move backwards to explore

a disruption between my personal and professional identities, by looking within myself and outwards to the environment. I examine how my interactions with others have shaped, and continue to shape, my experiences. Through telling of my personal and professional stories, I have come to understand how I took on a caregiving role to help my family (my mother in particular), in an effort to find a place to belong after my parents' separation. This experience taught me to seek belonging in a similar way as an adult, by becoming a professional caregiver: a nurse.

As I re-visit key moments from my time as a nursing student, new graduate, and current practitioner, I gained insight into the influences of these (personal) childhood experiences, on my (professional) behaviours as a nurse. This allows insight into the reciprocal nature of my personal and professional identities, and my inquiry puzzle.

Through this reflection I also recognize deeply rooted, maladaptive patterns that have remained with me since childhood, such as the belief that I must practice as a caregiver in isolation from my colleagues, and a tendency towards self-sacrifice. As I revisit these experiences, I re-construct the narrative of my life by creating new meaning from them. With this new insight into my professional identity as a nurse, I can move forwards to create stronger, more supportive relationships with my patients and colleagues, as my new awareness of self allows me to fully engage with them.

I also realize that I remain driven to help people, and my wish is to continue to do this through my work as a nurse. To apply my cog metaphor, by rediscovering the inner parts of myself, I gain a deeper understanding of my unique position as a health care provider, and what I can and cannot do. As I learn to appreciate my most inner nature, I can redirect energy to care for myself, strengthen my propulsion, and become a more efficient piece of the great health care machine.

In sharing what I learned and where I am heading from this self-study, I hope that I can inspire other health care professionals to reflect inwards to engage in their own personal-professional experiences. I invite them to consider their life stories to recognize the value that their work holds in their lives, and how their values and beliefs might inform their perceptions, behaviours, and professional practice.

APPENDIX A

Ryerson University

Christina Di Stasi <christina.distasi@ryerson.ca>

Ethics Application - No REB Review Required

rebchair@ryerson.ca <rebchair@ryerson.ca> Mon, Jun 11, 2018 at 5:11 PM
To: christina.distasi@ryerson.ca, jschwind@ryerson.ca

Re: REB 2018-243 "The reciprocal relationship of self and practitioner: A Narrative Inquiry self-study"

Dear Christina Di Stasi,

The Research Ethics Board has determined that your protocol does not require its review.

Thank you for your application for ethics review for the above noted study. Based on the information provided in your application, it seems that this project is more of a self-reflection piece (than, per se, autoethnographic) and outlined that no specific stories would be shared, rather it would be a project in which you would reflect, quite generally, on your own work experiences, as described. As a result of much more emphasis on the reflective aspect of the study, rather than the descriptive element, we deemed it not to require review. Should your proposed methodology change, please reapply to the REB for ethics review and approval. Good luck with the project.

If you have any questions regarding your submission or the review process, please do not hesitate to get in touch with the Research Ethics Board (contact information below).

Record respecting or associated with a research ethics application submitted to Ryerson University.

NOTE: This email account (rebchair@ryerson.ca) is monitored by multiple individuals. If you wish to contact a specific member of the Research Ethics Board, please do so directly.

Yours sincerely,

Dr. Patrizia Albanese, PhD
Chair, Ryerson University Research Ethics Board
(416)979-5000 ext. 6526
palbanes@soc.ryerson.ca
rebchair@ryerson.ca
http://www.ryerson.ca/research

Dr. Asher Alkoby, LL.B., PhD
Vice-Chair, Ryerson Research Ethics Board
(416)979-5000 ext. 2491
aalkoby@ryerson.ca
http://www.ryerson.ca/research

Toni Fletcher, MA
Research Ethics Co-Ordinator
(416)979-5000 ext. 7112
toni.fletcher@ryerson.ca

Zakiya Atcha, MSW
Research Ethics Co-Ordinator
(416)979-5000 ext. 4841

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