EXPLORING THE SALIENCE OF OCCUPATIONAL IDENTIFICATION TARGETS AND TURNING POINTS IN NURSES' CAREER TRAJECTORIES

by

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For those who selflessly care for others

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TABLE OF CONTENTS

LIST OF TABLES

ABSTRACT

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Nursing is one of the most important professions in the United States but it has historically endured high levels of shortage and turnover (Apker, Propp, & Ford, 2009; Fox & Abrahamson, 2009). A nurse's organizational climate and culture have been shown to impact a number of job outcomes including intention to leave the organization (Aiken & Patrician, 2000), and therefore is of interest to both scholars and practitioners alike. One way to understand the context in which nurses work is through organizational identification because people make sense of their own identities in part through the organizations to which they belong (Kuhn & Nelson, 2002). However, because individuals have various identities which can reinforce but at times conflict with each other (Scott et al., 1999) and the strength of these identities can dictate outcomes such as performance (Trybou, Gemmel, Pauwels, Henninck, & Clays, 2013), it is necessary to explore how nurses connect to different identities and social collectives (e.g., team, organization, and occupation/profession) within their work. Further, these connections with the multiplicities of identifications may help explain the decisions that guide nurses' career trajectories as well as how the perceived identity of a nurse guides individuals to choose a career in nursing. This project seeks to understand how nurses talk about their jobs and how communicating with other nurses influences their career trajectory and decision to stay in or leave their organization or the nursing profession altogether.

This project draws upon both social identity theory and self-categorization theory to help explain how nurses communicate and situate themselves among others in their workplaces. Social identity theory and self-categorization theory are suited for this study's social constructionist approach and the topic of this research because they explain how the strength and multiplicities of identification within an organization are constructed and shaped by communication with others. Data collection methods for this study consist of in-depth interviews with nurses of specific licensures, posts collected online from a nurse discussion forum, and a questionnaire of nurse forum participants. This study applies a mixed methods approach consisting of qualitative and quantitative analyses. In doing so, this project contributes in several ways including extending our understanding of (1) the connections between the multiplicities of identification; (2) how nurses construct meaning in their jobs to guide career decisions; (3) the nature of nurses' interactions in online spaces; (4) nurse career decisions; and (5) nurses' perceptions of the nursing profession before entering the profession.

CHAPTER 1. INTRODUCTION

Nursing is considered an extremely important profession, but it is also associated with a number of challenges. For instance, a shortage in nurses in the United States has endured throughout time, as it has been documented in the research literature for nearly a century (Fox & Abrahamson, 2009; Spohn, 1954). One reason for the shortage is that nursing is well-known as a stressful profession with high levels of burnout (Khamisa, Peltzer, & Oldenburg, 2013). Sources of stress, among myriad other outcomes for nurses, have been attributed to a variety of individual and organizational factors. The term "outcomes" in nursing refers to nurse job indicators such as stress, burnout, job satisfaction, and intent to leave a job (Kutney-Lee, Stimpfel, Sloane, Cimiotti, Quinn, & Aiken, 2015).[1] The American Nurses Credentialing Center (Magnet Model, n.d.) further delineate empirical outcomes into categories of "clinical outcomes related to nursing, workforce outcomes, patient and consumer outcomes, and organizational outcomes" (n.p.).

The research literature is replete with studies investigating a number of these outcomes yet some have been largely ignored. For example, nursing literature is brimming with research which identifies numerous individual level factors responsible for outcomes within nursing work as well as the impacts these individual level factors have on the organization and patients. Some of these factors include commitment, demographic factors, external locus of control, maladaptive coping styles, motivation, organizational citizenship behavior, and self-esteem (e.g., Fox & Abrahamson, 2009; Green, Albanese, Shapiro, & Aarons, 2014; Kimberly & Evanisko, 1981; Li,

[1] "Outcomes" in nursing can also refer to a patient's health status as a result of a nursing intervention (Nursing Outcome, n.d.) but for the purpose of this study it is strictly referred to the nurses themselves.

Early, Mahrer, Klaristenfeld, & Gold, 2014; Singer et al., 2009). These variables[2] and others have been examined in their relation to job outcomes including burnout (e.g., Melchior, van den Berg, Halfens, Huyer Abu-Saad, Philipsen, & Gassman, 1997), compassion (e.g., Li et al., 2014), job satisfaction (e.g., Khamisa, Peltzer, & Oldenburg, 2013), innovation adoption (e.g., Kimberly & Evanisko, 1981), safety-climate perception (e.g., Abrahamson, Ramanujam, & Anderson, 2013; Singer et al., 2009), and shortage of nurses(e.g., Fox & Abrahamson, 2009). Due to the number of studies focusing on these individual level factors alone, scholars argue that there needs to be a shift to consider organizational level factors or the organizational context of climate and culture in which nurses work (Green et al., 2014). As Sovie (1984) notes, there is "no single factor, but a constellation of variables" within healthcare organizations that lead to nurse job outcomes (p. 85). Attending to organizational contexts can not only lead to creating effective organizational interventions to help reduce stress, burnout, and turnover, it can help to illuminate nurse career decisions and perceptions of their careers which can contribute to reducing burnout and improving outcomes for nurses, health organizations, and patients (Green et al., 2014).

Scholars have acknowledged the need to study the organizational context in which nurses work and how it influences various nurse outcomes. For example, Aiken and Patrician (2000) note the importance of organizational context on some of these job outcomes:

> Theoretically, patient, nursing, and institutional outcomes are affected by the environment in which care is delivered. Nursing can be thought of as an organization's surveillance system, in that nurses are present around the clock. When nurses are given authority in line with their responsibility, autonomy, and control over patient care

[2] Variables and factors are used interchangeably here. In reference to factors and outcomes, individual level and organizational level factors are responsible for a number of outcomes in nursing.

> resources, they are in a better position to establish positive relationships with physicians. In addition, nurses functioning in such an environment can apply resources as appropriate for best meeting patient needs and for communicating problems to the physician in a timely manner. Theoretically, these environmental factors are responsible for better patient, nurse, and organizational outcomes. (p. 2)

Further, even though the literature repeatedly identifies individual factors which contribute to outcomes such as burnout, it is becoming increasingly apparent that burnout may also be attributed to factors within the larger organizational context (Green, Albanese, Shapiro, & Aarons, 2014). These findings suggest a need to attend to aspects of the organizational context instead of only considering factors at the individual level.

One way of understanding the context in which nurses work is through organizational identification. People make sense of their own identities in part through the organizations in which they belong (Kuhn & Nelson, 2002). Organizational identification is defined as "a perceived oneness with an organization and the experience of the organization's successes and failures as one's own" (Mael & Ashforth, 1992, p. 103). Because people have various identities which can reinforce but at times conflict with each other (Scott et al., 1999) and the strength of these identities can dictate outcomes such as performance (Trybou, Gemmel, Pauwels, Henninck, & Clays, 2013), it is necessary to explore how nurses connect to different identities and social collectives (e.g., team, organization, and occupation/profession) within their workplace. Further, these connections with the multiplicities of identifications may help explain the decisions that guide nurse career trajectories as well as how perceptions of the identity of a nurse guides individuals to choose a career in nursing.

Importance of this Study

The research literature widely cites nursing as a profession with high levels of stress, burnout, and turnover (Apker, Propp, & Ford, 2009) and the shortage of nurses has been recognized as an issue worldwide (Halperin & Mashiach-Eizenberg, 2014). Organizations have prioritized nursing recruitment as well as retention efforts (Halperin & Mashiach-Eizenberg, 2014). Further, Halperin and Mashiach-Eizenberg note that "methods to identify and guide appropriate students toward nursing is generally lacking" (2014, p. 1331). Therefore, it is important to understand why individuals choose to enter the nursing profession, as this information can not only help healthcare organizations in their recruitment efforts and potentially help reduce the nurse shortage, but also assist students and other young people in choosing a career. There is some research which has sought to understand why nurses choose their careers. I will address this issue next as well as gaps within this research, both of which highlight the need for the current project.

Extant research has identified a number of reasons why nurses choose to enter into their profession.[3] For example, Larsen, McGill, and Palmer (2003) found that both motivating factors and characteristics about the nursing profession played a part in influencing career decisions. Motivating factors include oneself or a loved one being sick or in the hospital, previous experience in healthcare, or knowing someone close who was a nurse. Some characteristics about the nursing profession which influence someone's decision to become a nurse include having a genuine concern to help others, the prospect of job security, and various work settings.

[3] I will use the word "profession" here to describe nursing work instead of "occupation" because "profession" indicates a level of commitment to the work overall that may stem of higher levels of education and training required for that work. Certain lower licensures of nurses may more often consider their work as simply a job or occupation instead of a lifelong career or profession. This is discussed further, later on. However, for the purpose of this discussion, these terms may be used interchangeably.

These motivating factors did not differ between nursing programs. Another study, conducted by Halperin and Mashiach-Eizenberg (2014), found that the main factor which influenced students to enter into nursing was altruistic motivation, followed by professional interest. Materialistic factors like salary and social status were less influential in students' career decisions. Finally, a systematic literature review of factors motivating healthcare students to choose their career revealed four main themes: intrinsic factors (i.e., wanting to help others or being personally interested in working in healthcare), extrinsic factors (i.e., money, job security, and prestige), sociodemographic factors (i.e., gender and socio-economic status), and interpersonal factors (i.e., family influence) (Wu, Low, Tan, Lopez, & Liaw, 2015). The interest in understanding why nurses choose their careers is not recent; in fact, Kersten, Bakewell, and Meyer (1991) note that "nurse educators across the country are interested in why students choose nursing as a career" (p. 30).

Although there is sufficient justification for the factors that motivate nurses to enter their profession, we know little about how they talk about these decisions, especially in online spaces. There is some evidence to show that nurses do in fact use the internet to communicate with each other and others about their jobs to strengthen intra-professional ties and information access (Valaitis, Akhtar-Danesh, Brooks, Binks, & Semogas, 2011), form supportive communities (Brooks & Scott, 2006), and network and obtain job information (Morris, 2005). Yet researchers have not tapped into how nurses use online spaces to communicate about their career decisions. This is a topic worthy of further research given the above-average rates of turnover within the nursing industry. Findings from this study will be valuable not only to researchers who study how individuals communicate online about careers, but also to nurses to understand the influence

of their peers and themselves in others' career decisions and to healthcare organizations seeking to increase retention of nurses.

Additionally, given what we know about the high level of turnover and burnout among nursing professionals, research suggests some influence of organizational identification over nurse job outcomes such as job satisfaction and intent to leave an organization. Although some studies have found that nurses may identify more strongly with their profession than their organization (e.g., Apker & Fox, 2002), there is a lack of findings to confirm whether nurse outcomes are "independently influenced by identification with different organizational targets" (Johnson et al., 2006, p. 501). Further, although some (e.g., Corwin, 1961; Strauss, 1962) have suggested a connection between identification and career trajectories, scholars have yet to take a closer look. Turning points leading up to and during one's career can alter one's choice in career and its trajectory, which in turn can change one or multiple of that person's identities (Flinkman et al., 2013). This study seeks to explore not only individuals' decisions to pursue a career in nursing but also how nurses may identify with different targets within their organization and how those identities may play a role in nurses' career trajectories.

Theoretical Frameworks

This project draws upon two theoretical frameworks: social identity theory and self-categorization theory. Tajfel's social identity theory explains the role of the self within social group behavior (Tajfel & Turner, 1979). Tajfel (1972) defines social identity as an "individual's knowledge that he belongs to certain social groups together with some emotional and value significance to him of this group membership" (p. 292). People will compare their 'in-group' with 'out-groups' in ways that positively differentiate their group from the others (Hogg, 2016). Turner (1985) extended social identity theory to consider self-categorization theory to

include the individual identity in the organizational context. This theory explains how "social categorization produces prototype-based depersonalization of self and others and, thus, generates social identity phenomena" (Hogg & Terry, 2000, p. 123). Further, self-categorization is viewed as "that component of an extended social identity theory of the relationship between self-concept and group behavior that details the social cognitive processes that generate social identity effects" (Hogg & Terry, 2000, p. 123). Self-categorization theory and social identity theory are important to consider together as the self is a vital component of organizational identification.

This study also applies a social constructionist meta-theoretical framework. From a social constructionist perspective, knowledge is not just an independent construction within someone's mind but it is something that is formed through communication with others (Gergen, 1985). Therefore, what we "know" is arrived at through the process of communicating with others – in other words, our perceptions of reality are a "social invention" (Davis & Cox, 1994, p. 39). Building from this description, we can view healthcare teams, and specifically nursing, as containing meaning which is created continuously through communication. These meanings and ways of communicating can evolve to change how nursing is viewed over time. Additionally, this framework can provide particularly useful explanations about individuals' decisions to choose nursing as a career based on interactions with others about the profession.

Based upon the gaps in extant literature and the theoretical frameworks guiding this study, I pose the following research questions:

RQ1: How do nurses communicate in online spaces about their work?

RQ2: How do nurses talk about what it means to be a nurse?

RQ3: How have previous interactions with other nurses influenced nurses' perceptions of identification with various targets both before and after becoming a nurse?

RQ4: With which target(s) of identification do nurses most strongly identify, and why? The rationale for each of these research questions will be built further in the next chapter. Next, I will briefly introduce the research methodology used in this project.

Methodology

Data for this study consist of in-depth interviews with nurses of various licensures, posts collected online from a nurse discussion forum, and a questionnaire. I conducted interviews with 35 nurse participants, collected 600 posts from the forums, and received 440 questionnaire responses from nurses on online discussion forums. Upon securing approval from the university's Institutional Review Board, I worked with faculty and the director of the nursing program at a large Midwest university to recruit participants, which yielded nurse participants not only working in university settings but in healthcare organizations across the United States. Additionally, reddit.com revealed several nurse discussion forums—called subreddits—which provided ample posts for analysis as well as questionnaire participants.

Interviews were audio-recorded and transcribed and online posts were scraped from the forums manually. Once all data was collected, I read and re-read all interviews and online texts based on steps prescribed by Tracy (2013) to uncover themes related to communication behaviors, career decisions, and targets of identification. For survey data I used SPSS to calculate descriptive statistics.

Contributions to Theory and Practice

This study provides a number of contributions to theory, practice, and methodology. First, findings contribute to theoretical understandings of the interplay between nurse identifications, turning points, career decisions, and online communication. Second, this study

provides insight into how nurses construct meaning about their jobs and how these meanings can lead them to make career decisions or decide to stay in or leave an organization. Third, the methods used in this study address a gap in the current literature using qualitative methods by analyzing narratives of nurses about their work experiences and turning points, as well as using online spaces to collect data. Fourth, given the high levels of turnover within the nursing profession as well as healthcare organizations' efforts to retain nurses (e.g., Halperin & Mashiach-Eizenberg, 2014), this study provides some insight into how management can recruit and retain nurses based on knowledge regarding career decisions and various identifications within an organizing context. Finally, findings from this study provide individuals who are considering entering the nursing profession with outlets in which to seek information in online spaces, as well as information to either strengthen or contradict their existing perceptions of nursing work.

Preview of Subsequent Chapters

Chapter Two provides a brief history of nursing and how nursing has been constructed over time as well as context on the organizational climate and culture within the nursing profession. The chapter also reviews relevant literature on communication in online spaces, turning points and career trajectories in nursing, organizational identification, and connecting these concepts to address a gap in current research. The frameworks of social identity theory and self-categorization theory are used to explore how nurses may identify differently with various targets of their job which can shape career decision-making. This project addresses four research questions which are integrated within the literature review.

I will begin Chapter Three by exploring the social constructionist metatheoretical perspective guiding this project. I then explain the value of conducting mixed methods research

and how qualitative and quantitative methods can be combined for a thorough analysis of the data to address my research questions. I next describe participants and procedures, followed by details of the data analytic techniques.

Chapter Four addresses each research question in turn, integrating the research methods in order to answer each question. Findings for research question one reveal that most users of nurse online discussion forums use them to read what others say on a variety of topics and analysis of online posts identify six main ways in which nurse communicate within these forums. Research question two findings show that nurses talk about their work in a variety of ways, including describing the nursing profession, trends and issues in nursing, shortage and turnover, and defining moments. Research question three findings identify both positive and negative ways in which nurses influence each other's careers and career decisions. Finally, results for research question four show that nurses most strongly identify with their work teams first and foremost and findings also reveal reasons why nurses may identify with their teams, organization, and profession.

Finally, Chapter Five includes a discussion on theoretical, practical, and methodological implications as well as limitations and future directions. For example, this study contributes to theoretical understandings of the interplay between nurse identifications, turning points, career decisions, and online communication. This study also provides insight into how people considering nursing can find more information about the profession as well as how healthcare organizations can recruit and retain nurses. Additionally, this study's mixed methods design addresses gaps in research by qualitatively analyzing nurse narratives as well as using online data.

CHAPTER 2. LITERATURE REVIEW

A Brief History of Nursing

Nurses have historically played a large role in healthcare, sometimes being the sole provider of care in the absence of physicians (Hawkins & Bellig, 2000). However, the nursing profession in the United States has changed dramatically over the years. Early colonial America had not conceptualized of the modern day's nurse, and in fact, most of the care was provided by the women of the household (Brainard, 1922). This was not to say that the need for healthcare was not dire. Disease and illness ran rampant and slowly hospitals began to open, with the first one opening in the mid-1600's. The Nurse Society of Philadelphia was established in 1839, with the goal of providing assistance to physicians and caring for patients (Brainard, 1922). Nurses were originally volunteers and up until the Civil War began, there were no formal healthcare organizations which provided the military with medical attention. In fact, "sheds, barns, and churches around battlefields housed the sick and wounded, where volunteers cleaned and fed them, the primary patient care known in homes and hospitals alike" (Eiselein & Phillips, 2001, p. 239).

Specialization in nursing became more common in the early 1900's as some nurses entered graduate programs and went into areas such as administration and teaching. Clinical nursing specialists (CNS) came to be considered a legitimate concept only in the mid 1900's (Dunn, 1997). Shortly after, a definition of "nursing" was introduced by the American Nurses Association, followed by the development of official nurse practitioner (NP) programs (Dunn, 1997). According to Dunn, the concept of the clinical nurse specialist was in fact created to address the fragmentation of healthcare, which was in response to the end of World War II, as

well as the idea of a more complex healthcare system. The CNS role was developed in part to provide a knowledgeable individual who could also provide personalized care.

Looking specifically at women's health nursing in the United States, the evolution from the 19th century of home deliveries to today's high-technology care can be traced through overlapping social, scientific, and professional trends (Hawkins & Bellig, 2000). Hawkins and Bellig note such trends consist of specializations in nursing and specialty centers, shifting of women's roles in society, and regionalization. These changes were also seen in public health nursing as well, as it merged specialties with gynecological care as prenatal care and women's health became public health concerns. In addition to this brief historical account of how nursing came to be, the evolution of nursing from a constructionist perspective is of particular interest to the current study, and I will discuss next.

Understanding Nursing from a Constructionist Perspective

The earliest constructs of nurses in America have evolved significantly over time. With the opening of the Nurse Society of Philadelphia in 1839, nurses were strictly "pious and prudent women," and "women of good habits, quiet, and patient disposition, and with a sense of responsibility" were chosen to be nurses (Brainard, 1922, p. 192). Patient care was more holistic than today, as nurses spent a considerable amount of time with the patients and their families, not only caring for their illnesses but teaching them good habits such as proper hygiene (Brainard, 1922). The professional image of nursing has evolved over time and is still evolving today. Current views of nurses range from "caring do-gooders" to "angels of mercy" to those "having wildly exciting lives" (Fox & Abrahamson, 2009, p. 241). However, Fox and Abrahamson point out that the current constructed images of the nurse can and should be changed in some ways. They write: "Public service programs designed to recruit nurses which promote a positive, yet

realistic view of nursing as a sensible career path can assist in transforming nursing's public image from feel-good task, to rewarding profession" (2009, p. 242). However, some nursing licensures (e.g., Clinical Nurse Specialist, Nurse Practitioner) are viewed more positively or in different ways than others.

Dunn (1997) notes that nursing in the United States evolved in two specific areas: the nurse practitioner and the clinical nurse specialist professions. These different professions arose from varying needs of patients and from each came a distinct meaning associated with that profession. For example, "nurse practitioners became synonymous with primary and clinical nurse specialists with specialized, acute care" (Dunn, 1997, p. 814). Even further constructions of these professions exist within nursing and society, as Dunn states

> The clinical nurse specialists have a more respectable image among the powerful nursing education elite, but nurse practitioners are widely recognised by consumers and other health care professionals and are valued by cost-conscious managers as a viable, cheaper alternative to physicians. (p. 814)

Dunn further mentions the varying constructions of nursing based upon the different titles. For example,

> Controversy has surrounded the role of the NP since its evolution as to whether NPs look upon nursing issues differently from nurses in general and the specialist nurse in particular. Early writings about the role of the CNS were more likely to focus on the teaching role provided by the CNS to patients and relatives and providing a role model for staff. Considerable discussion concerned the CNS orientation to the psychosocial dimensions of patient care, in contrast to the NP's focus on technical activities that had previously been the responsibility of the physician (e.g. physical examinations, laboratory

> tests, diagnosis and treatment of illness and, in certain States, the prescription of medications). Clinical nurse educators believed the NP role followed the medical model of care whilst the CNS followed a nursing model. (1997, p. 817)

These constructions of the different nursing professions have evolved over time based on various, conflicting viewpoints on what it means to do these professions. Perhaps a lack of opposition to the 1964 Nurse Training Act can be attributed to the fact that the goals of the act aligned with socially constructed ideals of what nursing is. This act aimed to "support and upgrade nursing education" and "the CNS role was truly the response of nursing education to a perceived need to improve nursing care" (Dunn, 1997, p. 816). However, since the NP role was conceptualized quite differently, Dunn noted that it "was in direct contrast to the response of nursing education to NP programmes" (1997, p. 816).

There are a number of other factors within health care teams that are changing the nature of the work and forcing health care workers, especially nurses, to reconstruct the meaning of their work and the nursing profession. Some of these challenges include a sense of urgency to respond to multiple and competing demands and a rising complexity of the work (Eisenberg, 2008). Relatedly, another influence that contributes to the current image being constructed of nursing is nurse shortage. Although shortage within the nursing profession may initially not seem like a social construct, Fox and Abrahamson (2009) note that in addition to societal factors contributing to shortage, social constructs such as the cultural image and the evolving nature of nursing work play a large role. Societal factors which have influenced the shortage of nurses include demographic circumstances such as population decrease since the baby boomer period, low nurse wages, as well as a lack of staffed nurse educators resulting in tens of thousands of applicants being turned away. However, another important factor listed as contributing to nurse

shortage is the perception of nurse work. In addition to being considered a high stress and low paying profession, Fox and Abrahamson acknowledge that the

> U.S. healthcare system contains a safety climate which blames individuals for errors instead of the system or organizational failures that may really be at fault. Many nurses experience additional stress because of the idea that if they do make an error, punitive action may be taken against them. (2009, p. 238)

This construction of blame is another way in which the nurse image has been shaped over time. Since there is a lack of research on the number of nurses actually needed in the U.S. health care system, the nurse shortage may just be perceived (Fox & Abrahamson, 2009). This can partially be attributed to the perceptions of low-quality health care and how data is interpreted related to nurse shortage. Additionally, Goldfarb, Goldfarb, and Long (2008) note that the current professional standards view a shortage exists. However, Fox and Abrahamson state that

> A professional standards definition of shortage is highly dependent upon the source of the professional standard. A challenge in taking a professional standards approach is that there is not yet clarity among healthcare administrators as to how many staff are needed to provide quality care, or even what defines nursing care as quality care. (2009, p. 240)

Even so, just the perception of shortage has proven to be enough to draw government attention to address this problem.

According to Real (1990), the constructionist perspective views reality as a "creation" and holds that "Reality is not discovered through objective means but is agreed upon consensually through social interaction, through conversation. Things 'are' what we agree to call them" and "The observer stands within the system observed" (p. 3). This perspective suggests that the nursing profession could be viewed in multiple ways. The various ways of being viewed

could depend on the culture of the organization and a number of other factors shaped by nurses themselves and other health care workers, as well as patients and the community. Additionally, Eisenberg (2008) reminds us that

> Effective healthcare team communication is more than the accurate transmission of information. Healthcare teams are socially constructed groups situated at the intersection of multiple institutional and professional cultures. Consequently, very powerful social forces constrain how these teams can work together. In particular, socially accepted constructions of a rigid status hierarchy and a pervasive lack of time to work deliberately are just the two most apparent ones. In examining communication in healthcare teams, we must be sure to look both at the communication and the evolving context. (p. 19)

A constructionist approach provides an answer to transforming the public image of the nurse, as it allows individuals to "consider ideas as something that can be mutually discussed and consensually changed rather than as objective truths that are set in stone, unchangeable" (Davis & Cox, 1994, p. 40). Conversations within nursing groups, including nurse management, is one step toward promoting a positive change in the construction of nursing (Davis & Cox, 1994).

One challenge in achieving positive change is the construction of power and hierarchical structure in health care. Whereas two-way communication and mutual construction of meaning works well in a distributed system (Eisenberg, 2008), the traditional hierarchical bias in health care culture could hinder the image of nursing as being a rewarding profession. Eisenberg asserts that although the rules and roles within the health care team may pose an obstruction, utilizing new technology and ways of communicating effectively can break down these structures and lead to recreation of meaning within the nursing profession. Although nursing has come a long way from women volunteers providing medical care to soldiers in barns during the Civil War,

early constructions of nursing may still exist in today's nursing profession, thus making it necessary to further explore how these constructions influence perceptions of nursing among nurses and individuals considering a nursing career.

Organizational Climate and Culture in Nursing

To further explore the social constructions that occur within the nursing profession, it is important to understand the context of nursing. Two organizational level factors that are often cited in literature on nursing are organizational climate and culture, which I discuss next.

Nursing Climate

Organizational climate can be defined as "the shared perceptions of and the meaning attached to the policies, practices, and procedures employees experience and the behaviors they observe getting rewarded and that are supported and expected" (Schneider, Ehrhart, & Macey, 2013, p. 362). Organizational climate has been researched in relation to a number of indicators in health care professions, such as employee mental health (e.g., Bronkhorst, Tummers, Steijn, & Vijverberg, 2015), professional workplace relationships (e.g., Malloy et al., 2009), absenteeism, burnout, and workplace injuries (e.g., Stone, Du, & Gershon, 2007). Components considered in organizational climate research have included leadership style and characteristics, organizational resources, and performance standards (e.g., Schneider et al., 2013). Others have included components of job roles such as clarity, overload, and conflict (e.g., James & Sells, 1981), as well as autonomy, nurse-physician relations, and professional visibility (e.g., Poghosyan, Nannini, & Clarke, 2013). In fact, dozens of definitions of organizational climate exist, each one considering a different combination of components, ranging from those mentioned above to structure and values and norms (Poghosyan, et al., 2013).

As one way of categorizing organizational climate, Green, Albanese, Shapiro, and Aarons (2014) defined it as being either functional and/or stressful. Functional climates are

> characterized by perceptions of opportunities for growth and advancement (a work environment in which the employee perceives opportunities for personal advancement), high role clarity (a work environment in which the employee has a clear understanding of where they fit and how to work within the organization) and high levels of cooperation, indicated by a work environment in which the employee receives necessary help from coworkers and administrators to successfully complete their job. (Green et al., 2014, p. 4)

Alternately, a stressful organizational climate is associated with role overload and role conflict (Green et al., 2014). Although these authors looked specifically at organizational climate in relation to burnout, research has linked it to numerous other indicators such as those previously listed. Characterizing climate into functional and/or stressful is just one of many ways in which scholars have defined it. Another umbrella term often used when discussing organizational level factors in nursing is culture. Poghosyan, Nannini, and Clarke (2013) note that organizational climate and culture are often conflated or used interchangeably, which poses some challenges for researchers. To clarify, Poghosyan et al. conceptualize organizational climate as referring to "perceptions related to working conditions that can be measured, quantified, and changed" whereas organizational culture can be referred to as "qualitative perceptions of values, norms, and beliefs" (2013, p. 135). I will further discuss organizational culture next.

Organizational Culture

Similar to Poghosyan et al.'s definition, Schneider, Ehrhart, and Macey (2013) define organizational culture as

> the shared basic assumptions, values, and beliefs that characterize a setting and are taught

> to newcomers as the proper way to think and feel, communicated by the myths and stories people tell about how the organization came to be the way it is as it solved problems associated with external adaptation and internal integration. (p. 362)

Organizational culture has been associated with health care profession indicators such as nursing professionalism (e.g., Manojlovich & Ketefian, 2002), patient care (e.g., Wick et al., 2015), job satisfaction, and retention, among others (McDaniel & Stumpf, 1993).

It is commonly known among scholars that we have not reached an agreement on how to define organizational culture or what components might fit under this category (Schneider, Ehrhart, & Macey, 2013). Some of the components considered within organizational culture include abstractions such as values, experiences, work groups, and assumptions (e.g., Gershon, Stone, Bakken, & Larson, 2004; Jones, DeBaca, & Yarbrough, 1997). Organizational culture has also included a focus on leadership, structure, procedures, philosophy, and stories about the organization (Schneider et al., 2013). However, a frequent source on components of culture is Schein (2010), who lists three levels of organizational culture consisting of artifacts, espoused beliefs and values, and basic underlying assumptions. Artifacts are visible aspects such as clothing, language, emotional displays, observable behavior, and technologies. Climate is also considered an artifact of an organization's culture. To provide clarification to the above-mentioned conflation of these terms, Schein notes that "Some culture analysts see climate as the equivalent to culture, but it is better thought of as the product of some of the underlying assumptions and is, therefore, a manifestation of the culture" (Schein, 2010, p. 24). Espoused beliefs and values can be defined as "the values that are reported by management as core to the organization but that may or may not reflect the reality in the organization for members" (Schneider et al., 2013, p. 371). Finally, basic underlying assumptions are those which are

ingrained in the daily life of the organization and guide members on how to think and act (Schein, 2010).

One part of a nurse's organizational culture that is often addressed is how power plays a role in how nurses do their jobs and communicate with others, such as physicians. Nurse autonomy—which is the power to make decisions on patient care and take responsibility for these decisions (James, Simpson, & Knox, 2003)—is desired among nurses but not often achieved due to a hierarchical power imbalance between nurses and doctors that has been constructed throughout health care history. James et al. note that "An essential component of excellent nurse-physician relationships is equality based on *different but equal* knowledge and power, instead of professional nursing judgments that are subservient to decision made by physicians" (2003, p. 815). However, nurse autonomy is often hindered in patient care decision-making not only because of law but due to the hierarchical organization within the health care profession (Kuokkanen & Leino-Kilpi, 2000). Therefore, instead of taking on the power imbalance directly, nurses may find themselves working around these barriers in order to get the best care for the patient. Ways of effectively communicating with physicians to manage the power imbalance may be included in the narratives that nurses share with one another and therefore is of importance to the current project. Understanding all the components that are included in organizational climate and culture is helpful for this project because these components serve as a guide on what to look for when analyzing data in order to understand all that is included in how nurses socially construct their professions. Another contribution this project makes to communication research in nursing work is to acknowledge online spaces as a common channel which nurses use to communicate. Next, I will provide a brief review of what is currently known about nurse communication in online spaces.

Nurses and Communication in Online Spaces

Although the available body of research provide justification of the factors which motivate nurses to enter their profession, we know little about how they talk about these decisions qualitatively or in online spaces. However, there is some evidence to show that nurses do in fact use the internet to communicate with each other and others about their jobs. For example, a study on community health nurses showed that they participated in an online community to strengthen intra-professional ties and gain access to information (Valaitis, Akhtar-Danesh, Brooks, Binks, & Semogas, 2011). The researchers in this study found that the nurses used the online space to frequently share stories with each other. Brooks and Scott (2006) suggest the use of online communication technology for health care workers including nurses to interact with each other and form supportive communities. They found that participants shared knowledge and reflections as a way to achieve change in practice and also offered both information and support to one another. Additionally, Morris (2005) notes that "nurses can use the internet not only to look for new jobs but as a tool for networking, seeking support, and obtaining job information" (n.p.). Thus, we can see that nurses do in fact use online spaces to interact and share information and support, but researchers have not tapped into how nurses use online spaces to communicate about their career decisions.

An additional point of support to show the need for this research project is that scholars have found the usefulness of using online spaces for people to communicate about their career choices. In other words, people go online for information-seeking. One way individuals seek information in online spaces is in the form of mentoring. Knouse (2001) notes that "an alternative to personal mentoring is to use the resources and accessibility of the Internet as a means of mentoring, variously termed 'virtual mentoring' or 'telementoring'" (p. 163). Another

term for Internet mentoring is e-mentoring, defined as "mentoring aided by CMC, and most commonly refers to mentoring via e-mail, although it can also include the use of web-based media such as chat-rooms and discussion areas" (Headlam-Wells, Gosland, & Craig, 2005, n.p.). Knouse notes two functions that mentoring serves in career development. First, it provides instrumental support in the forms of coaching, career guidance, and performance feedback. Second, mentoring serves a psychosocial function, including reducing stress, discussing problems, and role modeling appropriate behaviors. While some of these functions closely connect to communication about career decision-making, it is also important to note that a problem with mentoring is that many people "do not have access to a mentor" (Knouse, 2001, p. 162). Hence, the Internet has been found to offer a number of advantages over traditional mentoring methods, such as immediate access to an array of information, a varied amount of feedback, coaching from a number of various mentors, privacy (so individuals can share personal narratives about career decisions honestly), and it is cost effective (e.g., students can access this information easily and organizations can post narratives about nurse career decisions to influence others to enter nursing).

Another way that individuals use online spaces is for career services that enable busy students to access them without time and space constraints. Meeting face-to-face with someone to discuss career decisions not only limits the number of people that someone can talk to but there is also the issue of scheduling a time and place to meet. Venable (2010) argues that "online discussion forums offer students the opportunity to post questions and comments to a group of people or just one person" (p. 87). This convenience would drastically increase the availability of information about nursing that someone considering a career could access. Building from this point, Hooley, Hutchinson and Watts (2010) suggest that these technologies not only provide

accessibility of professional support, but they also are used to create communities of learning. Individuals can communicate with others one-on-one or with many people, which "offers new potential for…career exploration" (Hooley et al., 2010, p. 4). However, Hooley et al. point out that we still know very little about how individuals communicate with one another online, such as how influential they are and how we filter information online. To address some of these questions which currently exist in terms of online communication, I pose my first research question:

RQ1: How do nurses communicate in online spaces about their work?

Based on what we know about nurse decisions to enter their profession, that nurses do talk in online spaces, and how online spaces are useful for people to talk about their career choices, this research question will be explored within online spaces but also through surveying participants about their online behaviors. In addition to how nurses communicate in online spaces, this project considers turning points as a force which can influence a nurse's career trajectory, which I address next.

Nurse Turning Points and Career Trajectories

Current studies within nursing career research seek to understand elements of the profession in order to address common issues among nurses such as job satisfaction, stress, and turnover (e.g., Callaghan, 2003; Fox & Abrahamson, 2009). In answering these issues, some scholars explore why young nurses leave their jobs and seek new careers (e.g., Flinkman, Isopahkala-Bouret, & Salantera, 2013), some have identified differences between clinical specialties and organizations and various preconceptions made by students about what the nursing profession is like (e.g., Hayes, Orchard, McGillis Hall, Nincic, O'Brien-Pallas, & Andrews, 2006), and others have found differences between nurses who choose their career early

in life or later (e.g., Barriball & While, 1996). One way to understand decisions leading up to a career choice or while at a current job is through analyzing turning points in an individual's life. Turning points can signify an event leading to some change (Baxter & Bullis, 1986) and have been found to influence career decisions and trajectories (Bosley, Arnold, & Cohen, 2009). However, there is currently a range of ways in which "turning points" have been defined in the literature and a lack altogether of studies which identify turning points associated with nursing career trajectories. Next, I identify studies within nursing career literature that have conceptualized turning points and some future opportunities for research within this area.

In searching for literature surrounding nurse career trajectories and associated turning points, I used a number of decision criteria, each associated with different terms related to turning points. First, I searched the term "turning points" and similar terms such as "critical points," "critical moments," "critical incidents," "decisions," "trajectories," and "choice" to find any research associated with career trajectories and their associated turning points. Within each of these searches, I added the words "nurse" and "nursing" with "career," "profession," "job," and "occupation" to each of the above-mentioned terms. For example, one complete search term I used was "nurse career turning points." I was also interested in finding literature associated with communication so I searched terms such as "nurse communication about career choice." I used all of these combinations to find extant literature in Google Scholar as well as the *Communication and Mass Media Complete* and *Cumulative Index to Nursing and Allied Health (CINAHL)* electronic databases. In addition to these searches, after I obtained relevant literature, I looked through those articles and books for references that cited additional studies that may be useful to my query.

There are surprisingly few studies related to nursing that look at turning points or even mention the word "turning point" but many of them refer to turning points in patient care (e.g., Shih, 1998) or changing health behavior (e.g., Kearney & O'Sullivan, 2003). Although the initial search of literature identified over 100 studies of interest, after sifting through these I narrowed the list to 42 studies that specifically looked at some element of turning points and/or career trajectories in nursing. From these 42, even fewer provided clear conceptualizations of turning points related to nursing careers. I describe some of these studies below.

Defining "Turning Points" in Nurse Career Literature

Argued in early turning point literature as something to describe "a unit of analysis in understanding developmental processes in romantic relationships" (Baxter & Bullis, 1986, p. 469), the term "turning points" has gained popularity and has been defined and conceptualized widely in organizational research. Turning points are not just helpful in understanding relationship processes but are "Conceptualized as any event or occurrence that is associated with change" (Baxter & Bullis, 1986, p. 470) in relationships or personal growth. Organizational and career scholars have identified turning points in members' work experiences or career decisions that provide valuable insight about their career trajectories (e.g., Bosley, Arnold, & Cohen, 2009; Dempsey & Sanders, 2010; Hodkinson, 2008). In fact, Lee, Kossek, Hall, and Litrico (2011) note participants' "accounts of internal personal growth and development, epiphanies or turning points that led them to make a change," such as seeing a job posting that immediately sparked interest and felt inspired to apply for that job, are most salient in their findings (p. 1544). Turning points have also been identified in health research in instances such as understanding the role they play in changing health behavior (Kearney and O'Sullivan, 2003). Bullis and Bach (1989a) argue that "Turning points are of central concern to a model which focuses on change points

rather than on a series of stable phases" (p. 202). Therefore, it is important to have an understanding of what counts as a "turning point" in order to conceptualize how they influence an individual's career trajectory.

It is worth noting that organizational research literature is replete with studies on turning points; however, there still exists a lack of research looking at turning points within health care research and, specifically, the nursing profession. Although such studies do exist, conceptualizations of 'turning points' vary. Thus, for the current exploration, I have used the above definitions from studies outside of nursing to guide my understanding of various ways that 'turning points' are conceptualized in order to identify nursing studies which reference this phenomenon. While some nursing studies discuss turning points in the career choice process, others cite turning points later in the nurses' careers which influence their decision to leave the profession or change organizations. Still other researchers reference the concept of turning points but label them differently. In some cases, a nurse's career decision is not necessarily something they 'wanted' to do—for example, someone may choose to be a nurse because it offers the flexibility to move if their partner needs to relocate for a job, or because their parents told them they had to become a nurse. A "career trajectory" implies there is a movement forward (but sometimes backward) in time and space but turning points could indicate a trigger which activates other processes, meaning that there could be a series of turning points or a process that eventually leads to a shift in one's career trajectory. Therefore, although some scholars offer specific definitions of what a turning point is, others provide varying examples. This also indicates that turning points are largely perceptual, so one person may see a memorable conversation with someone or an experience as a turning point, while others may not. Because of the perceptual nature of turning points, this project is grounded in a constructionist perspective

which seeks to understand the various interpretations of turning points in nurses' career decisions and trajectories. Next, I will describe some of the studies which have identified nurse turning points (also see Table 1 for some examples) and provide a brief overview of the study and how turning points are conceptualized in that study.

Turning points more clearly defined

Within extant literature, there are a few studies which identify clear turning points for nurses and provide clear conceptualizations of what entails a turning point. For example, in an early study of graduate and student nurses about differences between perceptions and reality of nursing roles, Corwin (1961) addressed turning points in status shift from graduating from a nursing training program and beginning the nursing career. He noted that while "Most transformations are so mundane they go unnoticed," he conceptualized turning points as "an incident of great conceptual and personal significance" (p. 604). These turning points in the process of shifting status may result in re-conceptualizing one's role as a nurse and a potential realization of a conflict between one's expectations and reality. Corwin found that this conflict may be greater in individuals who align more strongly with bureaucratic and professional role conceptualizations.

Ulrich (2009), in her exploration of factors which play a role in influencing nurses to choose midwifery, identified among her findings a theme of specific turning points which she labeled "epiphany moments." Epiphany moments were described as "a moment in time when it became clear to [participants] that they wanted to be a midwife" (Ulrich, 2009, p. 130). Ulrich noted that these moments occurred at different times and settings – such as during helping a patient, witnessing a birth, or speaking with other midwives – and influenced the participant to decide this was the career they wanted.

A final example, from a short piece containing nurse narratives, refer to turning points as "touchstones in a nursing career" in which "Without warning, you care for a patient or deal with an event and the way you nurse…maybe even the way you live…is changed for good" (Irvine, 1997, p. 59). Some examples within this report include a nurse who was reminded of the nursing values of perseverance, compassion, and hope after she spoke to a formerly comatose patient who remembered the nurse caring for her while she was in a coma; a teenage patient's death which taught one nurse how to grieve with families of patients and accept support from coworkers; and a nurse who learned to use humor in her work after witnessing another nurse have great success with patients by joking with them. The turning points mentioned in this report were ones that occurred after nurses were already employed but they greatly influenced the ways in which the nurses worked and even encouraged some to make major decisions in their careers.

Turning points emerging from the data

My literature search uncovered a few studies which describe how narratives about turning points emerged from the data. One example is a longitudinal study on reasons why young nurses leave the profession, as authors Flinkman, Isopahkala-Bouret, and Salantera (2013) did not intentionally look for turning points but found that they emerged in their participant interviews. They likened turning points to "meaningful events" described in the participants' narratives (p. 3). For example, the authors noted examples from nurse narratives that contributed to their decisions to leave their jobs, such as one nurse's boyfriend telling her that she was "too bright and talented for nursing work" (2013, p. 7).

Turning points as a gradual process

Some studies note turning points as more of a gradual process than a specific moment in time. For example, in Andersson and Edberg's (2010) study of first-year nurses' job experiences, they note the transition of these new nurses as they progress from being a "rookie" to gaining more responsibilities and feeling like part of the team. The authors provided an example of a turning point as being when the nurses were able to "allocate time among assignments and patients" and found it to be "an important shift in the process of becoming a genuine nurse" (p. 189). Along this journey, they noticed "shifts" in perspectives and focus, which told them that they were becoming a "genuine" nurse.

Other studies were more challenging to identify 'turning points' that occur within nursing careers because they use a variety of other words to describe them. MacNeil (1997) found certain patterns within rites of passage along the transition of changing from nurse to teacher. Instead of specific moments along the way, these 'turning points' indicated gradual changes in the process. For example, one participant in the study noted that they started feeling like a teacher when other people started seeing him/her as one.

Turning points in other terms

Some studies include examples which could be considered turning points but do not discuss this concept. For instance, Newton, Kelly, Kremser, Jolly, and Billett (2009) conducted a longitudinal multi-method investigation of factors which motivate people to enter the nursing profession. A study participant recounted receiving a letter from a relative of one of his patients who had passed away, thanking him for his care, and this letter served as motivation to continue along in his career. Although these instances were not specifically identified as turning points, they served as important moments in the participants' career trajectories.

Another study, by Kersten, Bakewell, and Meyer (1991), which sought to understand nurses' influences in choosing their career identified some general contributing factors such as nurturance, employment opportunities, and emotional needs. The authors used a questionnaire consisting of closed- and open-ended questions but did not include any specific examples in their findings about related turning points. However, although they did not identify or define turning points, they noted that participants mentioned certain turning point-type moments such as positive or negative experiences of being a patient themselves or having family or friends in health care which influenced them to enter the profession.

The above examples illuminate the various ways in which turning points have been identified in nurses' career trajectories. These turning points have been labeled as an incident, shift, moment, event, motivation, and even a gradual process or transition. However they were defined, they have signified for the nurse a time when something became clear or memorable and created some significance in their life which influenced their career trajectory in some way, whether it was to do their job in a certain way or to make a decision to stay with or leave an organization.

Table 1

Exemplar Studies and Various Conceptualizations of Turning Points

Scholar(s)	Study Purpose	Conceptualization of "Turning Points"	Research Method(s) Used
Andersson & Edberg (2010)	"describes nurses' experiences during their first year after graduation" (p. 186)	A "shift" in ability, perspective, or focus that marks a change	Qualitative content analysis of interviews

Corwin (1961)	"study of the conflict between conceptions of role and discrepancies between the ideal perceptions of role and reality among 296 graduate and student nurses" (p. 604)	"an incident of great conceptual and personal significance" (p. 604)	Questionnaire of graduate and student nurses
Flinkman, Isopahkala-Bouret, & Salantera (2013)	"investigate in depth why young nurses leave nursing profession and reeducate themselves for a new career" (p. 1)	"Meaningful events" and experiences (p. 3)	Longitudinal study with interviews
MacNeil (1997)	"to examine the career trajectories of nurse teachers" (p. 634)	Gradual changes in the process of shifting status	Ethnographic approach using interviews
Ulrich (2009)	"explore the factors that influenced nurses to choose midwifery as a career path" (p. 127)	An "epiphany moment;" "a moment in time when it became clear" (p. 130)	Qualitative content analysis of education program applications

Addressing the Gaps in Extant Research on Nursing Turning Points

Based on the above analysis of extant nurse turning point and career trajectory literature, there were some additional gaps that should be addressed in future research. First, much of the research focusing on the nursing profession and career decisions, turning points, and trajectories were conducted outside of the United States. Some of this research comes from Australia (e.g., McCabe, Nowak, & Mullen, 2005), Finland (e.g., Flinkman, Isopahkala-Bouret, & Salantera, 2013), Israel (e.g., Halperin & Mashiach-Eizenberg, 2014), Pakistan (e.g., French, Watters, & Matthews, 1994), Saudi Arabia (e.g., Mebrouk, 2008), Sweden (e.g., Andersson & Edberg, 2010), Taiwan (e.g., Lai, Peng, & Chang 2006; Shih & Chuang, 2008), and United Kingdom (e.g., Callaghan, 2003). An exception to this is a study conducted by Ulrich (2009), which looked at United States midwife nurses. Ulrich focused her study of factors influencing nurses to become midwives in the United States, as she addressed a shortage of nurse-midwives with statistics specific to this country. It was necessary to distinguish this research specifically to the United States because other countries cite midwifery as more mainstream and more highly chosen as a career. Additionally, Aiken et al. (2012) conducted a study of nurses and patients in the United States and across numerous European countries to measure patient safety, satisfaction, and quality of care. They found some differences between the United States and Europe in these areas and also noted that the United States varies from other countries in workload and health expenditures. This suggests that previous work on turning points in nurse career trajectories conducted in other countries might not be applicable to the United States' nursing profession and therefore research should be extended to confirm previous findings locally.

A second clear gap in the existing literature on nurse turning points is in communication research. Naturally, much of the work done in this area has come from nursing journals (e.g.,

Andersson & Edberg, 2010; Flinkman et al., 2013; MacNeil, 1997; Ulrich, 2009). However, although turning point research has been conducted by communication scholars (e.g., Baxter & Bullis, 1986; Bullis & Bach, 1989a/1989b), organizational and health communication research has not attempted to address turning points in the nursing profession. Communication scholars are especially poised to conduct research in this area because communication choices are salient in the process of responding to turning points, and how one responds to a turning point leads to outcomes in relational development and other areas (Johnson, Wittenberg, Villagran, Mazur, & Villagran, 2003).

Based upon the extant research, there is limited work done on nursing career decision-making and the associated turning points in these decisions, both in the United States and in communication research. The above findings within nurse turning point and career decision literature have led me to my second research question:

RQ2: How do nurses talk about what it means to be a nurse?

This question is intentionally broad to understand the types of interactions that occur within nurse communication, such as the narratives and particular words they share. It also addresses the decision-making process both in terms of first deciding to become a nurse as well as during a nurse's career, when turning points can occur which may influence or force a nurse to change their career trajectory by leaving their organization or the profession entirely. If 'what it means to be a nurse' is socially constructed, then it is necessary to look at the entire process to consider what is being communicated not only once a nurse has started working but before someone even decides to become a nurse. My next research questions concern not only how turning points may play a role in influencing a nurse's career decisions and trajectory, but also how interactions with other nurses and talk about work shape various identities within the workplace. I will next

explain the connection between turning points and career trajectories with organizational identification.

Connecting Nurse Turning Points and Career Trajectories with Organizational Identification

One area of inquiry which poses an especially interesting opportunity for organizational and health communication researchers interested in turning points and career trajectories in nursing is within organizational identification. Some extant research makes the connection between these topics but does not fully investigate it, urging scholars to conduct future research in this area. Strauss (1962) has acknowledged that some turning points within a nurse's career can lead to a change in their organizational identity. One example states

> every student nurse early in her training must face the situation of having a patient die in her arms. For some nurses this appears to be a turning point for self-conception: the test is passed and she – in her own eyes at least – has new status; she can now think of herself as more of a professional. (Strauss, 1962, p. 69)

Similarly, around this same time, Corwin (1961) discussed that "At these turning points fundamental terminological and status shifts occur, reclassifying and reassessing the job—indeed, the self" (p. 604). These types of turning points can shape a nurse's identification with their profession, organization, and self, but research since then has not explicitly explored this phenomenon.

Other nursing studies have also acknowledged the relationship between (a) turning points/changes and career trajectories with (b) identification. For example, Flinkman et al. (2013) argued the use of case-centered research to uncover how nurses might encounter changes in their career which can lead to shifts in identities. They noted that some participants

experienced a conflict between their career choice in nursing and adhering to traditional identities of what a nurse is. MacNeil (1997) found that turning points in a nurse's career could threaten existing identities, as "identities come from the expectations attached to the social roles which we occupy which we then internalize" and "every role in society has attached to it a certain identity" (p. 641). This is important to explore because when an individual experiences loss of identity during a transition process it can lead to anxiety or stress (MacNeil, 1997), which is a common outcome in the nursing profession.

Additionally, work in the area of organizational socialization make another connection between identification and the career literature. For example, before entering the workforce, young adults have no prior experience of how to be an organizational member so "because social systems are integrated across time and space, inexperienced newcomers inevitably rely on relevant anticipatory knowledge" (Scott & Myers, 2010, p. 91). Therefore, the idea of 'what it means to be a nurse' is probably constructed over time leading up to and after the decision to become a nurse. Further, once an individual enters an organization, through socialization and/or assimilation their organizational membership constantly changes and becomes reconstructed over time (Scott & Myers, 2010). This also suggests that a decision to become a nurse or a nurse's decision to leave an organization may not be made in just one moment and it encompasses more than just the initial decision. It is important to understand what is happening communicatively during their time both prior to joining an organization and during the time as a nurse. This matters to the extent to which a nurse feels attached to or identifies with various targets within the organization and profession that have been shown to be related to indicators such as intent to leave, burnout, and job satisfaction.

Finally, Bullis and Bach (1989b) acknowledge that a turning point analysis would be helpful in understanding organizational socialization (which can influence identification) and identification for a number of reasons. The authors state that turning point analysis:

> (1) does not assume that the socialization process follows a clear pattern of growth as do phase models and identification research, (2) allows a detailed examination of change points identified by participants rather than relying on researcher-generated definitions, (3) collects self reports in such a way that participants need not rely on their memories of events which occurred in the distant past, and (4) relies entirely on the reports of individuals who are actively involved in socialization processes to report their experiences rather than relying on the organization's perspective. (1989b, p. 276)

These suggestions provide an outline for the current project to contribute to further understanding of nurse career decision-making and trajectories and associated turning points in the specific vein of organizational identification.

As mentioned previously, turning points have been noted as being influential in career decisions and trajectories (Bosley, Arnold, & Cohen, 2009) but there is a gap in the extant research which addresses these turning points in nursing. Further research is needed to understand how turning points both prior to and after entering the nursing profession can shape a nurse's career trajectory, as turning points may lead to certain decisions which may dictate a particular path or trajectory for a nurse's career. Additionally, as several scholars have indicated a relationship between turning points and identification, this project seeks to further explicate how turning points and career decisions play a role in shaping a nurse's identification with various aspects of their profession and organization. I will further discuss organizational identification and the associated targets below, but first I will describe social identity theory and

self-categorization theory as the theoretical framework of this project, as these theories provide the background of understanding further discussion about organizational identification.

Theoretical Framework

This project seeks to explore how nurses talk to each other and about their career decisions and how this communication shapes and uncovers various targets of identification within the nurses' organization. Therefore, this project draws upon both social identity theory and self-categorization theory to help explain how nurses communicate and situate themselves among others in their work. Social identity theory and self-categorization theory are suited for the social constructionist approach and the topic of this research because they explain how the strength and multiplicities of identification within an organization are constructed and shaped by communication with others.

Social Identity Theory

Tajfel's social identity theory (SIT) explains the role of the self within social group behavior (Tajfel & Turner, 1979). Tajfel (1972) defines social identity as an "individual's knowledge that he belongs to certain social groups together with some emotional and value significance to him of this group membership" (p. 292). People compare their 'in-group' with 'out-groups' in ways that positively differentiate their group from the others (Hogg, 2016). SIT suggests that "individuals tend to classify themselves and others into social categories and that these classifications have a significant effect on human interactions" (Nkomo & Stewart, 2006, p. 522). Ashforth and Mael (1989) note that this classification serves two functions in which "it cognitively segments and orders the social environment, providing the individual with a systematic means of defining others" and it "enables the individual to locate or define *him*- or

herself in the social environment" (pp. 20-21). In other words, this theory explains how individuals define themselves in relation to the groups in which they belong and how they align with the group's successes and failures (Ashforth & Mael, 1989).

Originally SIT was used as a theory of intergroup conflict (Kuhn & Nelson, 2002), but Ashforth and Mael together shifted the focus to organizational contexts such as socialization. They explain that one's definition of self is built through symbolic interactions by communicating with others (e.g., speaking with other nurses about their job) to create some meaning of who they are. This broadened application of SIT spurred an evolution of the theory to various organizational research, as Nkomo and Stewart (2006) state that

> SIT theorists have advanced the conceptualization of identity to: (1) identify specific contextual influences on identification processes (evoking salience and content); (2) identify the influence of two-way or reciprocal identification processes between organizational/workgroup members; and (3) address more fully the notion that members of any given social group or category vary in the extent to which identity group membership is a central and salient aspect of their overall self concept. (p. 522)

This is particularly relevant in understanding how nurses engage in the communicative act of socialization to learn what it means to be a nurse, as this project will uncover what nurses talk about which influences specific constructions of a nurse's identity.

Since SIT was rooted in social psychology (e.g., Tajfel & Turner, 1979) and the communicative process is not often at the forefront of SIT research, this lends to an assumption that the theory is not communicative enough. However, communication scholars are increasingly realizing how SIT can be well suited for communication scholarship. In fact, Scott (2007) provides a thorough argument on how SIT has and can continue to be used in communication

research on organizational identification. He identifies five specific areas where some research already exists, which include "salience of dual/multiple identifications, computer-mediated communication and virtual work related to identification, relationally focused work identities, organizational-level identities, and disidentification and related forms" (Scott, 2007, p. 123). For example, Scott, Corman, and Cheney (1998) highlight how communication plays a central role in creating social identities. Another example of particular interest to the current project is Postmes, Spears, and Lea's (2000) study of computer-mediated organizations, in which Scott describes "one of the clearest points of integration between communication and SIT has been their efforts to look at how social identities are socially constructed during the interactions of online groups" (2007, p. 127). These studies and others indicate rich scholarship which has extended communication research and opened new opportunities for the integration of communication and SIT.

Additionally, Scott notes that the time has come for further integration of SIT and communication research, citing reasons such as that it can help us to further understand issues in identification and organizing, it allows communication scholars to work with other disciplines to extend research, and it encourages scholars to assess current measures and develop new measures of organizational identification. The current project specifically answers the call to further explore communication processes that particularly matter in forming multiple identities (Scott, 2007). Next, I will briefly discuss self-categorization theory and then further address how both theories are of particular relevance for the current project.

Self-Categorization Theory

Social identity theory and self-categorization theory are important to consider together as the self is a vital component of organizational identification. Turner (1985) extended social

identity theory to consider self-categorization theory to include the individual identity in the organizational context. Self-categorization is viewed as "a development of social identity theory, or, more accurately, as that component of an extended social identity theory of the relationship between self-concept and group behavior that details the social cognitive processes that generate social identity effects" (Hogg & Terry, 2000, p. 123). This theory explains how "social categorization produces prototype-based depersonalization of self and others and, thus, generates social identity phenomena" (Hogg & Terry, 2000, p. 123). Further, "To the extent that they identify with, value or want to be accepted by the group, individuals internalize and attempt to conform to these prototypes" in which these prototypes can also serve to reduce one's uncertainty within the group (Nkomo & Stewart, 2006, p. 523).

Self-categorization theory uses the social self-concept to explain how groups work. The social self-concept can be described as "the system of cognitive representations of self based upon comparisons with other people and relevant to social interaction" (Turner & Oakes, 1986, p. 241). Turner and Oakes (1986) discuss several basic ideas of self-categorization. First, "Cognitive representations of the self take the form (*inter alia*) of 'self-categorizations'" which are "a cognitive group of the self as identical (similar, equivalent, interchangeable) to some class of stimuli in contrast to some other class of stimuli" (1986, p. 241). In the social self-concept, self-categorizations exist in three major levels of abstraction, including

> self-categorization as a human being (the superordinate category) based on differentiations between species, in-group-out-group categorizations (the self as a social category) based on differentiations between groups of people (class, race, nationality, occupation, etc.) and personal self-categorizations (the subordinate level) based on

> differentiations between oneself as a unique individual and other (relevant) in-group members. (Turner & Oakes, 1986, p. 241)

It is further noted that these different levels of categorization may take salience in different situations in order to decrease intragroup differences. This theory helps to explain how nurses form identifications with various targets in their jobs, such as their immediate workgroup, their organization, and as a nurse in general.

Both SIT and self-categorization theory are particularly relevant in understanding the aim of the current project: how nurses communicate with each other about their jobs and career decisions, as well as how they identify with various groups within their organization and profession. For one, these theories can explain how the majority of the nursing workforce still consist of women because the first formal nursing positions were solely women, and how issues of power and hierarchy have been longstanding issues within the nursing profession. Further, the act of constructing or transforming the image of the nurse or any other public image requires mutual discussion and consensual change (Davis & Cox, 1994). Thus, these theories are well suited for the social constructionist approach of this project because it illuminates the process of how identities are constructed through communication with other nurses. Next, I will further discuss organization identification and the various targets with which organizational members can identify.

Organizational Identification

One way in which people understand their own identities is through the organizations to which they belong (Kuhn & Nelson, 2002). The concept of organizational identification is defined as "a perceived oneness with an organization and the experience of the organization's successes and failures as one's own" (Mael & Ashforth, 1992, p. 103). People can have a number

of identities such as gender, ethnic, occupational, and others (Scott, 1997) which can all play a part in an individual's identity within their organization, so it is important to consider the multiple targets in which an individual can identify within an organizational context. Scott and Stephens (2009) point out that "probably the most examined alternative version of identification measurement focuses on various targets of attachment" (p. 373). These are sometimes labeled 'foci' (van Dick et al., 2006), or 'nested' identities (Ashforth & Johnson, 2001). Scott et al. (1998) argue that we must consider the multiplicity of social identities which connect people to various groups, and they specifically distinguish between four different targets of identification within organizations, including the organization itself, the individual, work group, and occupation[4].

Targets of Identification

Individuals can have multiple ways of categorizing themselves, such as by where they work, who they work with, gender, ethnicity, and others. Burke's (1937) research on various corporate identities and Kahn's (1990) idea of multiple dimensions of self even highlight this point. Scott (1997) takes these premises and notes that these identities "correspond to what are often called identification targets" (p. 495). These targets can reinforce one another but at times they may conflict with one another (Scott et al., 1999), highlighting the importance of considering the context and intersections of each of these targets (Bullis & Bach, 1989a). Ashforth and Johnson (2001) note that "certain identities are nested or embedded with others" (p. 32), with the job itself and the work group being considered lower order identities and the division/department and the organization being higher order identities. There are also cross-

[4] Here the term "occupation" could instead mean "profession" depending on the individual's view of their work.

cutting identities such as formal commitments like workplace committees and informal identities like friend groups at work (Ashforth & Johnson, 2001). As in all occupations, nursing also can correspond to various targets of identification, including their individual, team (or department), organization (often a hospital or health care center), and occupation of nursing. Next, I will break down these four major targets of identification in organizations, consider the influence they have in organizational contexts both in and outside of nursing, and finally highlight where gaps in research currently exist.

Individual identification

The first target of identification to consider is the self and the role it plays in one's overall identification within the organizations to which they belong. Turner (1985) extended Tajfel and Turner's social identity theory to consider self-categorization theory to include the individual identity in the organizational context. This theory explains how social categorization creates a "prototype-based depersonalization of self and others" and as an individual internalizes the group prototype their identity may change to align more closely with that of the group (Hogg & Terry, 2000, p. 123). As a theoretical framework in this project, self-categorization theory and social identity theory are important to consider together as the self is a vital component of organizational identification. In fact, one's professional or organizational identity may be closer to someone's self-identity than other identities such as gender, age, nationality, and others (Hogg & Terry, 2000). Hence, we should include the identity of the individual when studying organizational identification among nurses because it is a pervasive part of their overall sense of who they are and can include various aspects of their lives in addition to their organizational identification.

Team identification

Another important target of identification to consider is that of the team or work group, which is often a more proximal target than the organization as a whole. In nursing, the team could be the department or specialization within a hospital. Research suggests that identification with one's work group or other proximal targets is often stronger than identification with the organization (e.g., Marique, Stinglhamber, Desmette, & Goldoni, 2014; van Knippenberg & van Schie, 2000). Marique et al. (2014) make the point that this aligns with Brewer's (1991) optimal distinctiveness theory which states that employees identify more closely with the team because it is smaller and is less of a threat to one's individual identity than the organization is. Others have found that identification with the team or occupation is more closely linked to some work-related attitudes and behaviors like job satisfaction, job involvement, and job motivation (van Knippenberg & van Schie, 2000). Therefore, identification with the team or work group is critical to consider separately but in conjunction with one's identification with their organization.

Organizational identification

Probably the most common target of organizational identification research is the organization itself, which is a more distal target than the team or work group. For nurses, the organization would be their employing institution such as the hospital in which they work. Apker and Fox (2002) state that

> in organizational contexts, identification happens when individuals consider the organization's interests and values as relevant in the process of evaluating alternatives. It stems from the message sent from administration to employees that link individuals to the organization's core values, mission, and goals. Communicated through company newsletters, training sessions, informational and task work groups, and superior-

> subordinate interactions, messages can either weaken or strengthen employees' identification with their organizations. (p. 107)

When an employee identifies strongly with their organization, they are more likely to not only perform the tasks required by their job but also go above and beyond their normal duties to help the organization (Trybou, Gemmel, Pauwels, Henninck, & Clays, 2013). Some other benefits of positive organizational identification include employees adopting the organization's perspective, making decisions aligned with the organization's best interests, and reducing employee uncertainty (Apker & Fox, 2002).

Professional identification

Finally, organizational members can identify with their profession as a whole. This is often based on individuals' educational background; for example, part of a nurse's identity would be that they are a nurse and this part of their identification stays with them even if they move from one hospital to another. Trybou et al. define professional identification as "a type of social identification that denotes the degree to which employees identify themselves with the profession that they practice and their typical characteristics" (2013, p. 375). These connections to one's professions can be made at a young age when someone first begins their education but it can strengthen when they move between organizations and they may also identify with many groups at once with varying degrees of attachment (e.g., Russo, 1998). Apker and Fox (2002) offer an example that a nurse working in a hospital may feel a stronger professional identification as they are struggling with changes in their organization, which could result in a conflict between organizational and professional identification targets. They could leave their organization in pursuit of another nursing job while still maintaining a high level of professional

identification. Again, the potential conflict between targets illuminates the need to consider various targets of identification simultaneously.

Influence of Various Targets of Identification

Generally, research literature has focused on organizational identification as a moderator or a direct factor in influencing or predicting various outcomes for organizational members. However, few studies locate specific targets of identification in organizations. In many studies, these targets have become conflated so it is unclear which target (i.e., team, occupation, organization) would have more influence over these outcomes. Hickson and Thomas (1969) note that jobs fall somewhere on a professionalization continuum, with more professional occupations such as doctors and lawyers being distinguished from less professional occupations. This suggests that people would identify with various targets differently based on their specific job. Johnson, Morgeson, Ilgen, Meyer, and Lloyd (2006) point out two reasons why identifying with multiple organizational targets can be a challenge for employees:

> First, professionals may identify more strongly with their profession than with their employing organization, producing potential conflicts between professionals and their organization's expectations for their behaviors. Second, professionals may be more committed to their profession than to their employing organization, potentially leading to great turnover and fewer prosocial organizational behaviors. (p. 498)

Given what we know about the high level of turnover and burnout among nursing professionals (e.g., Apker & Fox, 2002), the above statement could suggest that nurses may identify more strongly with their profession than with their organization. Recognizing the various targets of identification provides a helpful way of understanding the multiple attachments of organizations (Scott, 1997) and the research shows that these "different identification targets have a number of

differential organizational implications" (Johnson et al., 2006, p. 499). Next, I will highlight some important research done in nursing that study certain targets of identification, and then I will move onto some studies which have considered multiple identification targets simultaneously.

Identification target research in nursing

In much of the extant nursing literature on identification, researchers focus on one specific identification target. For example, Tangirala and Ramanjuam (2008) studied personal control and voice and how they relate to organizational identification. They defined voice as "employees' expression of challenging but constructive opinions, concerns, or ideas about work-related issues" and personal control was defined as "employees' belief that they have autonomy on the job as well as an impact on important work outcomes" (Tangirala & Ramanujam, 2008, p. 1189). The authors found a U-shaped relationship between personal control and voice, and that organizational identification moderated the relationship between personal control and voice: "At low levels of personal control, voice was lower for employees with stronger identification. At high levels of personal control, voice was higher for employees with strong identification" (2008, p. 1197). These authors looked specifically at organizational identification and the target examined was the hospital.

Another recent study in nursing, by Vieira, Alves, Monteiro, and Garcia (2013), looked at organizational identification and the degree to which it influenced experiences of pleasure and suffering of female nurses. They found that the perception of one's profession mitigates the professional identification with an organization, and they suggest weak professional identification can have a negative impact on workers' physical and mental health as well as organizational performance. Although these findings contribute to the body of literature, these

authors conflate the concept of organizational and professional identification when at times it seemed like they were referring to team/work group identification.

A third study, by Katrinli, Atabay, Gunay, and Guneri (2009), looked at organizational identification with job involvement and some job dimensions in a health care organization. They found that "job involvement, which is the degree of importance of one's job to one's self-image, is related to organizational identification" (2009, p. 66). Although they noted the importance of studying organizational identification with job dimensions such as task autonomy, skill variety, task identity, task significance, and others, they found no significant relationship between them.

There are some similarities in the above research studies. First, these studies and the majority of others in the existing body of research literature employ quantitative methods to understand the relationship between organizational identification and various job indicators in nursing. Second, they do not consider specific targets of identification, but instead conceptualize all identification as 'organizational.' This is problematic as it does not consider the multiple and sometimes conflicting ways in which someone can identify with their workplace. Next, I will briefly highlight the few extant studies which have considered multiple targets of identification.

Multiple targets of identification within nursing research

In contrast to the number of studies which address organizational identification in nursing, there are few which consider multiple identification targets. One of the first studies which investigated multiple targets of identification in nursing was a qualitative study on how dress or clothing is used to represent various issues close to the multiple identities within a nursing unit (Pratt & Rafaeli, 1997). The findings of this study point to the importance of looking at multiple targets of organizational identification, as the issues highlighted by variations in dress reveal multiple identification issues, such as the nurses' mission, their clients, services/roles,

status/hierarchy, and decision making. The authors discussed different identities such as gender and professional identification and how "multiple identities play out in the context of one symbol in one organizational setting" (1997, p. 865).

Another study looked at both professional and organizational identification in nurses and nurse assistants in Belgian nursing homes (Trybou et al., 2014). They found that "organizational and professional identification moderates the relationship between perceived organizational support and extra role behavior positively" (2014, p. 374). Not surprisingly, the authors found that RNs identified with the organization and profession more strongly than nursing assistants, and employees with more than ten years of experience identified more strongly with both targets than the less tenured employees.

Another recent example of this research includes a study conducted by Marique and Stinglhamber (2011) which examined "the contribution of identification to proximal targets in the prediction of affective organizational commitment" (p. 107). The authors found that "occupational and workgroup identification were positively related to organizational identification for nurses" and that "organizational identification mediates the impact of both occupational and workgroup identification on affective organizational commitment" (2011, p. 107). These findings further highlight the importance of considering that multiple identification targets can have different influences on other targets as well as on other employee indicators in nursing.

Finally, Apker and colleagues have conducted the majority of nursing research on multiple targets of identification. For example, Apker and Fox (2002) found that "nurses held greater identification with their occupation than their organization" (p. 106) and that "nurses, regardless of their current job characteristics, background, and age, identified more with the

profession or nursing than with the hospital in which they were employed" (p. 111). Apker, Ford, and Fox (2003) then found that "high levels of autonomy and support by managers improved the nurses' identification with the hospital" and "high levels of autonomy, supported by colleagues, and duties focused on traditional beside care increased nurses' identification with the nursing profession" (p. 226). It is important to note from this study that support from a nurse's manager predicted organizational identification but not professional identification. A third study, conducted by Apker, Propp, and Ford (2009) found that "the relationship between promoting team synergy and intent to leave was partially mediated by team identification or by organizational identification" and "mentoring emerged as the only significant predictor of intent to leave; however, its relationship to intent to leave was fully mediated by organizational identification or partially mediated by team identification" (p. 106). These studies indicate that some work has been done that shows the importance of considering multiple targets of identification in nursing but that more research is needed to fully understand the various influences that different targets have on nursing indicators.

Although I have highlighted some important studies that have considered organizational identification in and outside of nursing, scholars (e.g., Johnson et al., 2006) recognize that very little research has actually looked at other targets of identification, let alone multiple targets at once. Research has shown that members of organizations can have multiple identities (Albert & Whetten, 1985) but despite this point, "empirical research on organizational identity still tends to treat it as a unified phenomenon" (Pratt & Rafaeli, 1997, p. 868). One point to highlight this is that individuals can work in an organization whose mission may or may not be consistent with their overall profession or personal identity (Johnson et al., 2006). For example, an individual trained to be a nurse could work in an organization where they may be a minority (such as a

school nurse) and the organization's mission could be drastically different than the overall mission of being a nurse, whereas the mission of a hospital may more closely align with traditional nurse training. Ashforth and Johnson (2001) note that more proximal targets, such as a team or work group, are often identified with more strongly than distal targets such as an organization. An additional gap in the literature is "whether job satisfaction is independently influenced by identification with different organizational targets" (Johnson et al., 2006, p. 501). To summarize, although some research has touched the surface of considering multiple targets of identification on nursing indicators, scholars still have much left to understand in this area. Therefore, based on the extant literature which highlights the need for more research on targets of identification within nursing, I have developed the following two research questions:

RQ3: How have previous interactions with other nurses influenced nurses' perceptions of identification with various targets both before and after becoming a nurse?

RQ4: With which target(s) of identification do nurses most strongly identify, and why?

Similar to my first two research questions, these questions focus on communication processes which take place related to nursing work. Since nurse shortage in the United States has been an ongoing problem (Fox & Abrahamson, 2009), in order for health care organizations to overcome this issue we need to understand how identification is formed both prior to and during entry into the workforce. These questions also acknowledge a connection between nurse careers and identification, which is a unique contribution of the current project.

CHAPTER 3. METHODOLOGY

Based upon the gaps in extant literature and the theoretical frameworks guiding this study, I propose the following research questions:

RQ1: How do nurses communicate in online spaces about their work?

RQ2: How do nurses talk about what it means to be a nurse?

RQ3: How have previous interactions with other nurses influenced nurses' perceptions of identification with various targets both before and after becoming a nurse?

RQ4: With which target(s) of identification do nurses most strongly identify, and why?

In order to address these questions, I applied a mixed methods approach, consisting of analyses of (a) qualitative interviews with nurses, (b) narratives and information voiced by nurses in an online forum for nurses, and (c) questionnaires of online nurse forum participants. Before detailing the methods applied in this project, I begin by describing the social constructionism metatheoretical perspective which guides this research. Then I discuss the benefits and practicality of using a mixed methods approach, followed by an overview of qualitative and quantitative research.

Metatheoretical Perspective: Social Constructionism

A social constructionist perspective provides an explanation of how society's constructions/perceptions of nursing as a profession have been shaped over time and how nursing has evolved to become what it is today. Social constructionism explains the process of how someone makes meaning of something through initially applying their experiences as a "reflective learning process" (Fejes & Andersson, 2009, p. 40). In other words, learning occurs though one's experiences and reflection upon those experiences as they form their

understanding. Constructi*vism*, originally coined by Piaget, led to the perspective of constructio*nism* by his student, Papert (Ackermann, 2001). Ackermann asserts that both Piaget and Papert are constructivists because they both see knowledge and the world as being constructed and reconstructed through an individual's experiences. Further, they view knowledge as

> not merely a commodity to be transmitted, encoded, retained, and re-applied, but a personal experience to be constructed. Similarly, the world is not just sitting out there waiting to be to be uncovered, but gets progressively shaped and transformed through the child's, or the scientist's, personal experience. (Ackermann, 2001, p. 7)

Ackermann argues that integrating Piaget's constructivism and Papert's constructionism "can enrich our understanding of how people learn and grow" (2001, p. 1). These are not two separate ideas but rather an expanded way of understanding how individuals create and recreate meaning in their minds based upon what they already know (Ackermann, 2001).

From a social constructionist perspective, knowledge is not just an independent construction within someone's mind but it is something that is formed through communication with others (Gergen, 1985). Therefore, what we "know" is arrived upon through the process of communicating with others – in other words, our perceptions of reality are a "social invention" (Davis & Cox, 1994, p. 39). Gergen (1985) notes that social constructionism "views discourse about the world not as a reflection or map of the world but as an artifact of communal interchange" and "Social constructionist inquiry is principally concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live" (p. 266). Additionally, social constructionism "attempts to articulate common forms of understanding as they now exist, as they have existed in

prior historical periods, and as they might exist should creative attention be so directed" (Gergen, 1985, p. 266). This perspective views communication not as a vehicle for transmitting information but as a social process through which we construct knowledge and meaning (Eisenberg, 2008). Eisenberg provides some illumination on how we might view health care through a social constructionist lens and the use of communication as an important way in which to create understanding:

> From a social construction perspective, efforts to improve information transmission are inherently limited because they fail to address how enduring patterns of communication both create and sustain a team's definition of itself and its situation. Seen this way, team communication is both about transmission and the social construction of reality, of the spoken and unspoken frameworks the team develops regarding appropriate goals, roles, and behavior. Focusing directly on the social construction of healthcare teams opens the possibility for deeper, second-order change that can be achieved through alterations in the social context. (2008, p. 10)

Building from this description, we can view health care teams, specifically nursing, as containing meaning which is created continuously through communication. These meanings and ways of communicating can evolve to change how nursing is viewed over time.

Additionally, social identity theory and self-categorization fit nicely within the social constructionist perspective. As discussed previously, these theories explain how identities are created and shaped through communication with others. Further, these identities can change over time through continuous meaning-making processes. Social constructionism also fits within both qualitative and quantitative research, especially when using a mixed methods approach because

both methods work together to confirm the accuracy of data analysis interpretations. Next, I will describe mixed methods research and its benefits.

Mixed Methods Research

When it comes to gathering and analyzing data, researchers in the social sciences generally fall into three broad categories of research methods which consist of quantitative, qualitative, and mixed methods (Johnson, Onwuegbuzie, & Turner, 2007, p. 112). Research paradigms should inform the research methods, and quantitative researchers (sometimes referred to as "QUANs") are typically guided by the positivist or postpositivist paradigms and work with numerical data and analyses, while qualitative researchers (sometimes referred to as "QUALs") mostly come from the constructionist (or interpretive) paradigm and concern themselves with narrative data and analyses (Teddlie & Tashakkori, 2009). Distinctions between quantitative and qualitative research methods call attention to some issues, which ultimately led researchers to consider ways in which they can integrate the two methods. Rynes and Gephart (2004) note a couple issues:

> First, qualitative research employs the meanings in use by societal members to explain how they directly experience everyday life realities. It builds social science constructs from members' "concepts-in-use" and focuses on the socially constructed nature of reality (Schutz, 1973). Quantitative, positivist research, in contrast, imposes scientific meanings on members to explain a singular, presumed-to-be true reality that nonscientists may not appreciate. Second, qualitative research starts from and returns to words, talk, and texts as meaningful representations of concepts. Quantitative research codes, counts, and quantifies phenomena in its effort to meaningfully represent concepts. Qualitative

> research thus has an inherently literary and humanistic focus, whereas quantitative research is grounded in mathematical and statistical knowledge. (p. 455)

Further, one problem between these different methodological approaches is that "There appears to be basic 'cultural' differences between" quantitative and qualitative researchers "in terms of the manner in which they are trained, the types of research programs they pursue, and the types of professional organization and special interest groups to which they belong" and these differences lend to "a distinct sense of community for each group" (Teddlie & Tashakkori, 2009, p. 4). Indeed, these two approaches vary widely in the ways in which they view knowledge and reality (Hathaway, 1995). Thus, it would seem difficult to integrate two different methodologies effectively. In working toward a more mixed methods approach, "An important issue is to balance the humanistic and literary aspects of qualitative research that focus on meanings with the demands for scientific knowledge based in mathematical or statistical reasoning" (Rynes & Gephart, 2004, p. 455). This is still a challenge that mixed methods researchers are working to address today. However, the mixed methods approach is fairly new, originating in the late 1980's within a variety of disciplines (Creswell, 2014). In search of a definition to encompass all that mixed methods are, Johnson, Onwuegbuzie, and Turner (2007) compiled a list of various mixed methods leaders' definitions, and they offer the following description:

> Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration. (p. 123)

Hence, for the current project, I seek to expand understanding of my research topic by applying a mixed methods approach consisting of qualitative and statistical methods. Next, I will further discuss some benefits of a mixed methods approach.

Benefits of Mixed Methods Research

There are a number of benefits to mixed methods approaches. In fact, a main assumption of using mixed methods research is that combining mixed approaches "provides a more complete understanding of a research problem than either approach [quantitative and qualitative] alone" (Creswell, 2014, p. 4). Mixed methods scholars are knowledgeable in areas of both quantitative and qualitative research as well as mixed methods research, and data analysis in mixed methods integrates both statistical and thematic techniques (Teddlie & Tashakkori, 2009). Mixed methods research also integrates both quantitative and qualitative data which can help to validate the accuracy of the data itself, mixed methods can lead to the development of better instruments, and one method can help to better explain the other or further illuminate the data in ways in which the other method could not (Creswell, 2014). Fetters, Curry, and Creswell (2013) note

> Several advantages can accrue from integrating the two forms of data. The qualitative data can be used to assess the validity of quantitative findings. Quantitative data can also be used to help generate the qualitative sample or explain findings from the qualitative data. Qualitative inquiry can inform development or refinement of quantitative instruments or interventions, or generate hypotheses in the qualitative component for testing in the quantitative component. (p. 2135)

Greene, Caracelli, and Graham (1989) developed a mixed methods conceptual framework from a literature review and found five purposes for mixed methods evaluations, which are described below:

1. Triangulation: “seeks convergence, corroboration, correspondence of results from the different methods.” Triangulation is used to “increase validity of constructs and inquiry results by counteracting and maximizing the heterogeneity of irrelevant sources of variance attributable especially to inherent method bias but also to inquirer bias, bias of substantive theory, biases of inquiry context.”
2. Complementarity: “seek elaboration, enhancement, illustration, clarification of the results from one method with the results from the other method.” This is important because it increases “interpretability, meaningfulness, and validity of constructs and inquiry results by both capitalizing on inherent method strengths and counteracting inherent biases in methods and other sources.”
3. Development: “seeks to use the results from one method to help develop or inform the other method, where development is broadly construed to include sampling and implementation, as well as measurement decisions.” Development is a benefit of mixed methods research because it increases “validity of constructs and inquiry results by capitalizing on inherent method strengths.”
4. Initiation: “seeks the discovery of paradox and contradiction, new perspectives of frameworks, the recasting of questions or results from one method with questions or results from the other method.” Initiation increases “the breadth and depth of inquiry results and interpretation by analyzing them from the different perspectives of different methods and paradigms.”
5. Expansion: “seeks to extend the breadth and range of inquiry by using different methods for different inquiry components.” Expansion increases “the scope of inquiry by selecting the methods most appropriate for multiple inquiry components.” (p. 259)

The benefits listed above are some of the ways in which mixed methods researchers can increase the validity of their research and feel more confident about their interpretations of the data than those who simply use just quantitative or qualitative research methods. One additional benefit of using mixed methods in social science is summed in a statement from Greene (2008), who says

> I believe that the mixed methods approach to social inquiry has the potential to be a distinctive methodology within the honored traditions of social science. I believe this because a mixed methods approach embraces multiple paradigmatic traditions and has or will have distinctive methodological components and distinctive markers of practice. But mostly I believe this because a mixed methods approach to social inquiry distinctively offers deep and potentially inspirational and catalytic opportunities to meaningfully engage with the differences that matter in today's troubled world, seeking not so much convergence and consensus as opportunities for respectful listening and understanding. (p. 20)

Thus, mixed methods approaches allow scholars to work together in ways in which they would have not been able to previously, which can move scholarly research forward to expand what we currently know and lend to both positive theoretical and practical implications.

Mixed Methods Research in Practice

The research literature is replete with mixed methods studies from a variety of disciplines, highlighting the advantages of integrating different methods of collecting and analyzing data. However, not all mixed methods studies are created the same. Some scholars still have a bent toward either qualitative or quantitative methods but integrate the use of the other to substantiate and confirm the accuracy of their data interpretations, while others try to use both

methods equally in their research. I will next provide some examples from each of these three applications.

One example of a study which used qualitative research methods as a primary approach and also integrated quantitative data and analysis was one by Luck, Jackson, and Usher (2008). They examined the meanings that emergency department nurses assigned to acts of violence from patients, family, and friends. By focusing on observations, semi-structured interviews, field interviews, and researcher journaling, paired with a structured observational guide to collect data on violent acts, they were able to show how mixed methods contributed to the rigor of their study by analyzing the data both thematically [qualitatively] and using frequency counts [quantitatively]. Another study, by Hamilton et al. (2013) sought to look at a quality improvement approach for employment services within mental health clinics. They collected hundreds of surveys but focused on qualitative data foremost by implementing field notes and interviews before, during, and after the implementation. These two studies highlight some ways in which quantitative data was used to supplement the main qualitative findings in the research.

Conversely, some scholars favor more quantitative methods and use qualitative methods to add further explanation to their research or to guide their quantitative work. For example, Myers and Oetzel (2003) created a measure of organizational assimilation by first interviewing employees from a number of organizations to suggest dimensions of organizational assimilation, and then they surveyed participants to validate those dimensions. This was primarily quantitative because the main focus of the study surrounded the hypotheses to find correlations between variables. Another study was conducted by Carr (2000) to examine the impact of pain on patient outcomes after they had surgery. They used surveys with numerical representations to assess 85

women for anxiety, depression, and pain after their surgery, and they integrated qualitative interviews with 37 of those patients in order to obtain further explication of their data.

A third approach that mixed methods researchers may use is to favor both quantitative and qualitative methods as equally as possible, using both methods to build on and improve the other. For example, Crabtree et al. (2005) looked at how clinical preventative services are performed in family clinics in order to further improve service. They used a case study design in multiple clinics and collected data through medical records, observations, patient exit cards, observations, and interviews to create a full report which offers approaches for delivering effective preventative services. Qualitative data led this project, but the researchers used statistical software to analyze chart audits and checklist data as a way to enrich the qualitative data. Another study, conducted by Saint Arnault and Fetters (2011) used surveys (with standardized and culturally adapted instruments) and interviews to understand how the illness experience, cultural interpretations, and social structural factors work together to influence how Japanese women seek help. These studies are only a sample of how researchers in mixed methods have used quantitative and qualitative research to improve their work and understand their data.

Applying a Mixed Methods Approach in the Current Study

As shown above, there are benefits and limitations to each of the mixed methods approaches. Some researchers (e.g., Morse, 1991) argue that it is not possible to equally favor both quantitative and qualitative research in a mixed methods study. However, others believe that it can be done. For example, Johnson, Onwuegbuzie, and Turner (2007) make the following argument:

[It] is based on our observation or interpretation that many philosophers of

> epistemology and/or science hold nuanced positions that typically involved a blending of assumptions, beliefs, and preferred analytical techniques…To address specifically the issue of mixing ideas associated with research paradigms, we have introduced a concept called commensurability validity or legitimation, which is "the extent to which the meta-inferences made [in a mixed methods study] reflect a mixed worldview based on the cognitive process of Gestalt switching and integration" (Onwuegbuzie & Johnson, 2006, p. 57). Commensurability legitimation will not be possible for many researchers, and it is difficult to learn how to switch perspectives and create new perspectives, but we believe that it is possible and desired. The strong (or fully) mixed methods position, we argue, is developed only after explicit and systematic consideration of qualitative and quantitative perspectives. (p. 126)

On the other side of this argument, Morse makes the point that a purely equally mixed methods approach may not be necessary, but that one method can serve an integral part of planning the next method, which she called "sequential triangulation" (1991, p. 120). For the purpose of my current study, I believe this approach offers the best method to address my research questions. Morse provides some helpful guidance on how to effectively use sequential triangulation with a favor toward qualitative methods:

> The first step in qualitative-quantitative triangulation is to determine if the research problem is primarily qualitative or quantitative. Characteristics of a qualitative research problem are: (a) the concept is 'immature,' due to a conspicuous lack of theory and previous research; (b) a notion that the available theory may be inaccurate, inappropriate, incorrect, or biased; (c) a need exists to explore and describe the phenomena and to

develop theory; or (d) the nature of the phenomenon may not be suited to quantitative measures. (p. 120)

It is also important to note that the method(s) chosen for research should be guided by a number of criteria, such as the research problem and questions, personal training and experiences, and the audience (i.e., advisors, journal editors and reviewers, and colleagues) (Creswell, 2014). While hypotheses/research questions that lend themselves to quantitative methods often seek to predict/find relationships between variables ("why" questions) and research questions that lend themselves to qualitative methods often seek to understand the "how" or "what" of a phenomenon, research questions that call on researchers to utilize a mixed methods approach seem to go "beyond" just one or the other (Creswell, 2015, p. 61). For example, for an explanatory study, one might seek to answer, "How do the qualitative data explain the quantitative results?" (Creswell, 2015, p. 61).

All four of my research questions can clearly be considered qualitative questions, as they seek to answer the "how" and "what" of nurse career decisions and identification. However, because understanding the "how" and "what" is the primary goal, it makes sense to choose a mixed methods approach which favors qualitative methods first and then integrate quantitative methods to support and triangulate my qualitative findings. Creswell suggests that mixed methods research questions can be written in a number of ways, such as by conveying "the methods or procedures in a study," conveying "the content of the study," or combining "the methods and content" (2014, p. 149). For example, I could ask the following questions about my methodological approach: Could nurse interview narratives help to explain results from surveys?; Does sharing narratives help to explain nurse career choices?; and How does the interview data with nurse narratives help explain why people who know nurses are more likely to

become nurses themselves? These are all ways in which I could present my approach. Creswell also states that these research questions could be presented differently in my study, such as by putting the questions in different sections to have quantitative, qualitative, and mixed methods questions separately.

To analyze the data collected, Fetters, Curry, and Creswell (2013) offer two steps in integration through data transformation:

> First, one type of data must be converted into the other type of data (i.e., qualitative into quantitative or quantitative into qualitative). Second, the transformed data are then integrated with the data that have not been transformed. In qualitative studies, researchers sometimes code the qualitative data and then count the frequency of codes or domains identified, a process known also as content analysis (Krippendorff, 2013). Data transformation in the mixed methods context refers to transforming the qualitative data into numeric counts and variables using content analysis so that the data can be integrated with a quantitative database. Merging in mixed methods goes beyond content analysis by comparing the transformed qualitative data with a quantitative database. (pp. 2142-2143)

For my study, although my research questions generally seek to explore the narratives of nurses talking about their career decisions and their various occupational identifications, I am also interested in understanding certain aspects within the narratives (such as specific turning points in their lives) which have influenced nurses to make their choices. For example, since I want to learn if there is a significant difference in characteristics between nurses who identify with different identification targets, I need to integrate a quantitative approach within my study. Due to the nature of my research questions and subsequent questions, applying a mixed methods approach which favors qualitative data and analyses (such as interviews) and is supplemented by

quantitative data and analyses (such as surveys and frequencies of certain statements from online posts) would be most beneficial. In my findings, I intend to present the quantitative findings of my study to show if there are significant differences in how nurses identify with their work team, organization, and profession. I will then focus on data from interviews to fully explain my quantitative findings and further illuminate the themes in ways in which nurses talk about their career choices and identifications. In applying a mixed methods approach, I can more fully understand and explain the phenomenon in which I am interested and enhance the validity of my results.

As noted above, I intend to apply a mixed methods approach in which qualitative methods are the primary focus. Next, I will discuss qualitative methods and its assumptions, and include some guidelines for conducting a high-quality qualitative study.

Qualitative Research

Qualitative methods have many advantages for research and scholars using them. According to Rynes and Gephart (2004), qualitative research "can provide thick, detailed descriptions of actual actions in real-life contexts that recover and preserve the actual meanings that actors ascribe to these actions and settings. Qualitative research can thus provide bases for understanding social processes that underlie management" along with other contexts (p. 455). Further, "qualitative research has potential to rehumanize research and theory by highlighting the human interactions and meanings that underlie phenomena and relationships among variables that are often addressed in the field" (Rynes & Gephart, 2004, p. 455). Qualitative research methods have made important contributions in every subdiscipline within communication. For example, in organizational communication, qualitative research has expanded theoretical knowledge in areas such as leadership, identification, socialization, innovation, and others

(Lindlof & Taylor, 2002). One important aspect of qualitative research is that it provides "description and understanding of the actual human interactions, meanings, and processes that constitute real-life organizational settings" (Rynes & Gephart, 2004, p. 455). Qualitative methods have an advantage over quantitative methods in this case because "The domain of naturally occurring meanings is highly accessible to qualitative research and distant from quantitative research" (Rynes & Gephart, 2004, p. 455). There are a number of standards or criteria of "high quality" qualitative research, which scholars work hard to maintain and evolve in their work. I will describe several elements of what a high-quality study would look like, but first it is important to understand some assumptions of qualitative research.

Assumptions of Qualitative Research

Although qualitative methods are thought to be typically used by interpretive scholars who seek to understand the meanings associated with specific phenomena, qualitative methods do hold value in other research paradigms as well. Hathaway (1995) notes

> The decision to use quantitative or qualitative methods is replete with assumptions concerning the nature of knowledge and reality, how one understands knowledge and reality, and the process of acquiring knowledge and knowledge about reality. When one chooses a particular research approach, one makes certain assumptions concerning knowledge, reality, and the researcher's role. These assumptions shape the research endeavor, from the methodology employed to the type of questions asked. (p. 536)

While some researchers focus on the benefits of combining qualitative and quantitative methods, others argue that "the different approaches make vastly different assumptions concerning knowledge and reality" (Hathaway, 1995, p. 539). Hence, it is not only possible but very common for researchers to conduct high quality studies that use only qualitative methods.

The popularity of qualitative research methods came about in part due to the adoption of the interpretive paradigm, which I described earlier. However, in understanding the connection between qualitative research outside of the interpretivist paradigm, Lin (1998) argues that qualitative research can be positivist too as it "can attempt to document practices that lead consistently to one set of outcomes rather than another, to identify characteristics that commonly are related to some policy problem, or to find strategic patterns that hold across different venues and with different actors" (p. 162). This argument shows that a high-quality study using qualitative methods is not done the same way every time; it must follow the aims of the research and guidelines of the paradigm of inquiry in which the researcher subscribes. Rynes and Gephart expand upon this point:

> Clearly, qualitative methodologies must be used in ways that are consistent with the theoretical or paradigmatic view(s) adopted and the specific problems being explored. This consistency is important so that the research process is capable of producing the kinds of data and analyses necessitated by the theory in use and the goals of research in the related paradigm. Two options could enhance consistency in theories and methodologies. First, scholars could adopt postpositivist methodological techniques from social science to enhance consistency between postpositivist theory and methods-in-use in management. Second, scholars could use interpretive or critical postmodern perspectives more often and adopt social science methods that were originally developed for interpretive and critical research agendas and purposes. (2004, pp. 457-458)

As stated earlier, the current project is adopting this latter approach by viewing the research problem through a constructionist (or interpretive) lens. Now that I have provided some

background of the assumptions behind qualitative research, I will further discuss elements of high-quality studies using qualitative methods.

Elements of Strong Qualitative Research

Just as scholars of objectivist research are concerned about high quality research, so are those who use qualitative methods (Lindlof & Taylor, 2002). Positivist and interpretivist researchers alike have created ways to evaluate the quality of qualitative research (Lin, 1998). Building from a traditionally dominant quantitative language, evaluation criteria has focused on showing reliability, validity, and rigor, in which "reliable and valid research is, by definition, rigorous" (Denzin & Lincoln, 2018, p. 760). Lin (1998) notes that although they may use the same terms, quantitative and qualitative scholars have different ways of evaluating the quality of their very different work. For example,

> Interpretivist work draws upon notions of credibility and accuracy of description to establish validity, not upon the evaluation of how often the variables are repeated and in what combinations. Interpretivists also have a different understanding of generalization, seeing it as the creation of taxonomies rather than as the discovery of causal relationships that operate across different times and spaces. (Lin, 1998, p. 169)

Reliability regards "the consistency of observations: Whether a research instrument…will yield the same results every time it is applied" (Lindlof & Taylor, 2002, p. 238). It is argued that reliability is not often considered in qualitative research due to the assumption of multiple and changing realities that are so close to interpretivist foundations. However, one way of achieving reliability in qualitative research is through intercoder reliability. For example, when I analyze themes in participant interviews, I would have a co-author or research assistant also code for themes in the data and we would compare our ratio of agreement to ensure reliability.

Validity is concerned "with the truth value of observations: whether a research instrument is accurately reporting the nature of the object of study and variations in its behavior" (Lindlof & Taylor, 2002, p. 239). Qualitative researchers in both post-positivist and interpretivist traditions "require the research process to consist of documented procedures, which can be described to outsiders and justified in terms of the knowledge one hopes to obtain" (Lin, 1998, p. 169). Hence, this is why researchers provide transcripts of interviews, field notes of observations, and keep track of participants and informants. Lindlof and Taylor note that in qualitative research, validity is accomplished through triangulation, by comparing multiple forms of evidence through multiple sources, methods, and/or researchers; and through member validation, by confirming the accuracy of findings with participants.

Additional strategies not previously mentioned which qualitative researchers use to ensure the quality of their research are saturation and peer review (Morse, 2018). Saturation aims to connect similar concepts across various instances. For example, when conducting interviews for my study I will not have a "set" number of interviews that I would aim to collect but instead I will continue to conduct participant interviews until I saw no new themes occurring in responses, or in other words "reached saturation." Peer review is also an important foundation for conducting a high-quality study because by presenting our work to colleagues for feedback we try to ensure that we are being ethical, have fully considered our arguments, and are overall conducting "good research." Thus, reputable academic journals are peer reviewed.

Tracy (2010) extends the conversation by suggesting eight criteria of all good qualitative research. First, it must have a worthy topic that is "relevant, timely, significant, interesting, or evocative" (Tracy, 2010, p. 840). Second, it must be rich in rigor with thorough data and context. Third, it should have sincerity, which "can be achieved through self-reflexivity, vulnerability,

honesty, transparency, and data auditing" (Tracy, 2010, p. 841). Fourth, it has credibility – identified by trustworthiness, concrete details, triangulation, and plausibility of findings. Fifth, good qualitative research is evaluated by resonance, or the ability to reach an audience through aesthetic merit, transferability, and naturalistic generalizations. Sixth, it makes a significant contribution and extends knowledge, improves practice, empowers others, and/or spurs future research. Seventh, it is ethical – including procedural, situational, relational, and exiting ethics. Finally, good qualitative research should have meaningful coherence which "achieve their state purpose," "accomplish what they espouse to be about," "use methods and representation practices that partner well with espoused theories and paradigms," and "attentively interconnect literature reviewed with research foci, methods, and findings" (Tracy, 2010, p. 848). It is clear that many of these criteria align with the above-mentioned standards of good qualitative research, but these are not the final say or the end of the conversation. Tracy argues that the discussion must be ongoing, as criteria of quality may be constantly changing.

Similar to Tracy's criteria and others noted above, Cohen and Crabtree (2008) reviewed published literature in health care research which discussed standards for evaluating good qualitative research. They found seven criteria, consisting of: 1) carrying out ethical research; 2) importance of the research; 3) clarity and coherence of the research project; 4) use of appropriate and rigorous methods; 5) importance of reflexivity or attending to researcher bias; 6) importance of establishing validity or credibility; and 7) importance of verification or reliability. We can see there is much overlap in the above cited sources about elements of qualitative methodologies, which shows that there has been much consideration among qualitative scholars about what makes a high-quality qualitative study.

In sum, there are a number of elements that must be considered in qualitative research to ensure that it is of highest quality. It is important to reiterate that the methods chosen are guided by the research questions/hypotheses of interest. For example, since I am interested in understanding how nurses talk about their decision to enter their profession, it would make sense to conduct interviews with multiple nurses, using interview guides that are created with questions that do not lead participants to answer in a certain way and are also based on extant research about career decision and turning points. I have conducted a literature review that shows gaps in existing literature and where I could contribute to existing knowledge about this topic, to ensure that this research is interesting and necessary. Importantly, I first gained approval from the university's Institutional Review Board to ensure that participants are protected and that I am collecting and storing data in acceptable ways. I triangulate my data by not only interviewing nurses from multiple organizations or points in their careers but also gather narratives from online discussion forums in which nurses talk about their career choice. Additionally, I have taken detailed notes about the research process, including how I recruited participants and reflected upon my interactions with participants; visited the data multiple times to see if new themes emerge; and maintained anonymity of participants. When analyzing my data, I can collaborate with a research assistant to independently code data and compare themes to achieve reliability. I could also have participants read the transcriptions and/or themes to confirm accuracy and as a way to reduce researcher bias. Of course, this is not an exhaustive list of considerations I would take but they point to examples of what is important to do when conducting good qualitative research. Next, I discuss both qualitative and quantitative data collection for this study.

Qualitative and Quantitative Data Collection

Data for this project include individual interviews, online posts, and a questionnaire. Taken together, these data were collected to address the four research questions of this study. Table 2 outlines each research question and the specific research methods that will be used to answer them.

Table 2

Research Questions and Corresponding Methodology

Research Question	Research Methodology
RQ1: How do nurses communicate in online spaces about their work?	1. Online posts 2. Questionnaires
RQ2: How do nurses talk about what it means to be a nurse?	1. Individual interviews
RQ3: How have previous interactions with other nurses influenced nurses' perceptions of identification with various targets both before and after becoming a nurse?	1. Individual interviews
RQ4: With which target(s) of identification do nurses most strongly identify, and why?	1. Individual interviews 2. Questionnaires

Method 1: Individual Interviews

First, individual interviews were conducted to help answer the second research question: *How do nurses talk about what it means to be a nurse?*, the third research question: *How have previous interactions with other nurses influenced nurses' perceptions of identification with*

various targets both before and after becoming a nurse?, and the fourth research question: *With which target(s) of identification do nurses most strongly identify, and why?* The interviews sought to understand how nurses feel and communicate about their work and working with other nurses, as well as how closely connected they feel to their work team, their organization, and the nursing profession.

Participants

Thirty-five nurses were interviewed for this study. Participants ranged in age from 24 to 64 years old, with an average age of 42 years. Although 16 (45.7%) of participants currently work at a university, most of them professors of nursing, every single participant had worked in a hospital setting at some point during their careers. All participants currently work in some nursing-related field where they apply their nursing expertise, whether it be from teaching nursing students to providing care remotely to working directly with patients at the bedside. The nurses worked an average of 16.4 years as a nurse, ranging from one to 45 years, and have worked an average of 5.5 years at their current organization. Four nurses indicated working at two organizations, so tenure was calculated using the organization for which they have worked the longest. All but two participants were female, which is nearly representative of the population given that only 9% of nurses in the United States are male (Certified Nurses Day, 2019). Fifteen (42.9%) of participants had earned a BSN (Bachelor of Science in Nursing) as their highest degree, and 28 (80%) indicated being an RN (Registered Nurse). A list of participants (listed by pseudonym) and their age, most advanced degree and title, current position, current organization type, time at current organization(s), and total years as a nurse is included in Table 3. Some participants worked at their current organizations before they became a nurse; hence, some indicate the time working at their current organization as longer than their

total years as a nurse. Further, many nurses have worked multiple roles and in different units during their tenure in their current organization.

Table 3

Interview Participants

Pseudonym	Age	Most Advanced Degree, Title	Current Position(s)	Current Organization Type(s)	Time at Current Organization(s)	Total Years as a Nurse
Amelia	24	BSN, RN	Pediatric Progressive Care Unit Nurse	Hospital	3.5	2.5
Andrea	40	MSN, RN	Clinical Assistant Professor	University	5	18
Ashley	52	PhD, RN	Clinical Assistant Professor	University	1	29
Brooke	25	BSN, RN	Intensive Care Nurse	Hospital	1.5	3
Carlos	34	BSN, RN	Lab Coordinator	University	2	11
Carmen	33	BSN, RN	Pediatric Nurse	Hospital	1	7
Carrie	50	MSN, RN	Pediatric Nurse, Continuing Lecturer	Hospital, University	9, 1	19

Chloe	45	DNP, RN	Clinical Assistant Professor	University	9	23
Dave	50	MSN, RN	Continuing Lecturer	University	1.5	22
Dawn	37	MSN, RN	Clinical Assistant Professor	University	3	17
Denise	47	BSN, RN	Case Manager	Care Management Company	5	24
Donna	64	MSN, RN	Clinical Assistant Professor	University	12	45
Erica	46	BSN, RN	Research Study Coordinator	Hospital	2.5	25
Heather	64	PhD, RN	Assistant VP of Patient Safety and Quality	Hospital	13	44
Heidi	39	MSN, RN	Clinical Assistant Professor	University	2	16
Jamie	56	BSN, RN	Emergency Room Nurse	Hospital	14	25
Jessica	61	MSN, FNP	Outpatient Nurse, Nursing Instructor	Outpatient Clinic, University	10, 1	10

Kim	62	MSN, NP	Assistant Clinical Professor	University	10	41
Lindsay	30	BSN, RN	Cardiac ICU Nurse	Hospital	8	8
Monica	47	PhD, FNP	Clinical Assistant Professor	University	1	13
Morgan	26	BSN, RN	NICU Nurse; Training Officer	Military Hospital	3	4.5
Natasha	37	MSN, FNP	Clinical Associate Professor	University	9	17
Pam	26	BSN, RN	Float Nurse	K-12 Schools	1	4
Patty	51	BSN, RN	Recovery Room Nurse	Hospital	21	18
Rachel	48	BSN, RN	Nurse Surveyor	State Health Survey Agency	1	18
Samantha	38	PhD, RN	Assistant Professor	University	10	16
Sandra	27	MSN, NP-C	Family Nurse Practitioner	Family Practice	3	5
Sharla	39	MSN, NP	Pediatric Nurse Practitioner, Nursing Instructor	Clinic, University	3, 3	10
Sienna	36	MSN, NP	Endocrinology Nurse	Endocrinology Office	6	13

Sophia	43	PhD, RN	Hospital PRN, Clinical Assistant Professor	Hospital, University	2, 2	14
Stephanie	24	BSN, RN	Cardiothoracic Nurse	Hospital	1	1
Tanisha	42	BSN, RN	Charge Nurse	University Health Center	1	5
Tiffany	33	BSN, RN	Neuro Trauma Nurse	Hospital	9	9
Tina	37	ADN, RN	Cardiovascular ICU Nurse	Hospital	1.5	5.5
Vanessa	58	PhD, RN	RN Residency Program Director	Hospital	6	32

Materials

Semi-structured interviews were conducted which asked nurse participants to describe their jobs and the dynamics of their work team, organization, and the nursing profession as a whole. They were also asked to outline their career path and the decisions they made along the way, as well as turning points or memorable moments which stuck out to them (see Appendix A for interview protocol). Semi-structured interviews are well suited within a constructionist paradigm and narrative inquiry because they allow researchers to ask participants probing questions in order to clarify and further understand participants' perceptions and experiences (Chase, 2018). Interviews are an appropriate method for this project because they not only help to answer most of my research questions, but they allow me to more deeply explore stories of participants' experiences and turning points related to their career.

Procedures

After first securing IRB approval, I contacted a faculty member within a nursing program at a large Midwest university in the United States, who agreed to disseminate my research study invitation to other faculty and nurses (see Appendix B for invitation). From there, some participants offered to share the study invitation with friends and coworkers who were also nurses. This snowball sampling technique was done in order to recruit participants from other organizations in order to reduce skewed sampling of nurses all from the same organization. Once a potential participant called or emailed me to state their interest, they were sent an email in which I introduced myself and provided them with a full project overview and an informed consent document (see Appendix C). Interviews were conducted either in person or over the phone and at the conclusion of each interview, participants were compensated with a $20 Amazon gift card. Funding for this project came from professional development funds from the Brian Lamb School of Communication at Purdue University.

Before beginning each interview, participants were asked to provide their verbal informed consent to participate. Interviews were audio recorded with the participant's permission and then transcribed. In total, 1,993 minutes of interview data were recorded, and interviews averaged 57 minutes each, ranging between 43 and 78 minutes. There were 615 single-spaced pages of transcribed interview text, averaging 17.57 pages per interview and ranging between 12 and 25 pages long.

After all interviews were transcribed, I read through each one to begin "open coding" to compare examples and identify similarities and differences (Corbin & Strauss, 1990). Open coding is done to "give the analyst new insights by breaking through standard ways of thinking about or interpreting phenomena reflected in the data" (Corbin & Strauss, 1990, p. 12). I also

compared interview and other data—from online discussion posts and both closed- and open-ended questionnaire responses—to each other to confirm consistency (Williams & Connaughton, 2012). After identifying codes in the data, I began categorizing them to find ways in which they relate to each other. The codes revealed several themes in which I developed memos. Tracy (2013) describes memos as consisting of the themes' descriptions and definitional properties, examples, and relationships to other codes. Analyzing the data in this way aligns with the narrative inquiry approach and allows me to look at each participant's experiences separately to interpret the perspectives and compare to others'. Although I did not approach the data analysis with an a priori list of categories, there are some themes for which I was specifically looking. I am interested in language that reflects specific targets of identification as well as turning points in nurses' career trajectories. For example, participants may not explicitly mention if they more strongly identify with their profession than their organization, so I coded for references that alluded to this.

Method 2: Online Posts

Second, online posts were collected to help answer the first research question: *How do nurses communicate in online spaces about their work?* Online posts were analyzed in order to understand the communication behaviors of nurses in online spaces and how they might talk about their work.

Procedure

In order to identify websites which contain data of interest to answer my research questions, I first searched Google for "nurse chat forums" to find common nursing forums. There were approximately 626,000 results, with most relevant findings including allnurses.com and

ultimatenurse.com/forum/. Additionally, I went to reddit.com and found hundreds of hits where nurses answered a variety of questions about their jobs and there was heavy interaction between members. Simultaneously, I had posted my survey invitation to several of these websites, as detailed below in Method 3's procedures, and received the majority of responses from reddit users. Because of this, I decided to collect online posts for this study solely from reddit so that it more clearly aligned with my survey findings. Specifically, I focused on the r/nursing subreddit because at the time of data of collection it was the most popular nursing-related subreddit, with over 92.8 thousand subscribers.

I collected the 200 most frequently commented upon posts from the r/nursing subreddit for the months of January, February, and March 2019, totaling 600 posts. Each post had between approximately 30 to 500 comments and allowed me to see the posts with which members were most engaged. The top 200 posts per month were easily extractable using https://redditsearch.io, which allowed me to sort by number of comments and specific dates. All posts were manually extracted, which involved copying the text of each original post by hand and pasting it into NVivo for qualitative analysis. Manually scraping the data was more efficient than programming a scraper through Python or another relevant scraper. In fact, Meneghello, Lee, and Thompson (2014) recommend that although using the Application Programming Interface (API) for social networking sites like Facebook or Twitter or using Google's Search API for blogs, it is best to manually scrape data from forums because it allows the collector to find content relevant to their search. To provide further support for this plan of extracting data, Lewis, Zamith, and Hermida (2013) note that a number of studies have manually scraped data from the Internet (e.g., Sjøvaag, Moe, & Stavelin, 2012). Finally, similar to the interview data, I read through each online post initially to begin "open coding" (Corbin & Strauss, 1990), and then identified themes which

emerged to develop memos (Tracy, 2013). Overall, there were six major themes into which each of the posts were placed, and each theme included counts of posts included, as described further in the findings.

Method 3: Questionnaires

Third, a survey was conducted to answer the first research question: *How do nurses communicate in online spaces about their work?* and the fourth research question: *With which target(s) of identification do nurses most strongly identify, and why?* The questionnaire sought to measure nurses' online activity as well as identification relevant to this study.

Participants

I initially received 635 responses to my questionnaire, and after cleaning the data to remove partial (less than 20% completed) and duplicate responses, 440 participants remained. 364 (82.7%) participants indicated that they were currently working as a nurse, 15 (3.4%) used to work as a nurse but were not currently, and 61 (13.9%) were currently working toward becoming a nurse. I was interested in understanding not only how nurses communicate online but also wanted to elicit responses from those working toward becoming a nurse in order to understand communication behaviors and decisions leading up to becoming a nurse, so the latter group was included in this study as well. Participants ranged in age from 18 to 63 years, and the average age of participants was 31 years (SD = 8.19). The average age of participants working toward becoming a nurse was 26 years (SD = 4.8), which differed from the average age of nurses which was 32 (SD = 8.37).

Of the 379 participants who were currently or used to be nurses, 26 (6.9%) are Licensed Practical Nurses (LPNs), 342 (90.2%) were Registered Nurses (RNs), 2 (.5%) were Clinical

Nurse Specialists (CNSs), 25 (6.6%) were Nurse Practitioners (NPs), and 16 (4.2%) indicated other, with participants being able to choose more than one option. 65 (17.2%) of these 379 nurse participants had been a nurse for less than one year, 107 (28.2%) for 1-3 years, 88 (23.2%) for 4-6 years, 59 (15.6%) for 7-10 years, 24 (6.3%) for 11-15 years, 18 (4.7%) for 16-20 years, 5 (1.3%) for 21-25 years, 7 (1.8%) for 26-30 years, and 6 (1.6%) for over 30 years. 14 (3.7%) nurse participants worked on average less than 10 hours per week, 17 (4.5%) worked between 10-20 hours per week, 32 (8.4%) worked between 21-30 hours per week, 237 (62.5%) worked between 31-40 hours per week, 64 (16.9%) worked between 41-50 hours per week, and 15 (4.0%) worked more than 50 hours per week. 288 (79.1%) of the 364 working nurse participants currently worked at a hospital, 22 (6.0%) worked in a nursing home, 22 (6.0%) worked in a health clinic, 13 (3.6%) worked in a private doctor's office, 11 (3.0%) worked in a school, 10 (2.7%) worked in home health, and 48 (13.2%) indicated other, which included jails/prisons, travel nursing, and others. It is common for nurses to work concurrently at more than one organization, and several participants indicated more than one option. Of the 377 nurse participants who indicated how long they had worked at their most recent organization, 103 (27.3%) had been there for less than one year, 161 (42.7%) for 1-3 years, 62 (16.4%) for 4-6 years, 27 (7.2%) for 7-10 years, 16 (4.2%) for 11-15 years, 2 (.5%) for 16-20 years, 5 (1.3%) for 21-25 years, and 1 (.3%) for more than 26 years.

Of the 61 participants who were currently working toward becoming a nurse, 18 (29.5%) were currently working in health care in addition to being a nursing student, in jobs such as an Emergency Medical Technician (EMT), a Nurse Assistant, or a Home Caregiver. 37 (60.7%) participants indicated they were strictly nursing students without employment, and 6 (9.8%) indicated having non-health care jobs such as a retail worker.

When asked to indicate which nurse-related online discussion forums they participate in, the majority of participants (n = 397) stated that they belong to various nurse-related subreddits on reddit.com. This was expected because reddit.com was the only online nurse discussion space in which I received permission to post my survey invitation, as noted below in the procedures. In addition to reddit.com, 41 participants used allnurses.com, 11 used justusnurses.com, 25 used various nurse-related Facebook forums, 3 used nursingvoices.com, 2 used ultimatenurse.com, and 16 used other forums.

Materials

In addition to in-person individual interviews and posts collected in online discussion forums, I created a questionnaire to survey participants on the above-mentioned discussion forums. This survey included closed- and open-ended questions about their participation in the forum(s), the ways in which they talk about being a nurse, their career trajectory and turning points in their career decisions, and how strongly they identify with identification targets of their immediate work team, their organization, and the nursing profession (see Appendix D). Questions to measure various targets of identification were based on Mael and Ashforth's (1992) 6-item Organizational Identification scale. I adapted this measure so that the six items relate to each of the three identification targets (sources) being measured. This adapted scale was used in addition to the aforementioned interviews and online forum interactions to triangulate findings on participants' level of identification with each target in their organization.

Procedures

Upon approval of the online forum administrators, I posted links to my questionnaire within several online nursing forums, specifically on reddit.com. I aimed to post the

questionnaire invitation to multiple forums in order to get a representative sample; however, I was surprised to find that most of the online discussion forums specifically for nurses were not actively moderated, as I did not receive a reply to my request from any of them. This is perhaps because it seems many of these forums are overrun with spam and the moderators may have perceived my message as such. However, some forums did not require approval to post so it is possible that my invitation was seen on other forums. Therefore, due to both the responsiveness of moderators and quality of content, after the initial requests I posted my survey invitation solely on nurse forums – or more specifically called subreddits – within reddit.com. I was unable to post in several nurse-related subreddits due to individual policies regarding self-promotion posts, but there were still several subreddits in which I received a high number of responses. These subreddits include r/NPPAJobs (365 members at the time of posting), r/Nurse (12.3k members), r/NursePractitioner (3.4k members), r/Nursing (92.8 k members), r/NursingJobs (427 members), r/NursingStudent (612 members), r/RegisteredNurses (682 members).

On each of the subreddit forums, I posted an invitation to my survey which included a link to Qualtrics, an electronic survey software (see Appendix E). I posted up to three times on each of the subreddits over the course of two months. Informed consent forms were included at the beginning of the surveys (see Appendix F). Compensation for completing the questionnaire included an entry into a drawing in which five participants were randomly selected and given a $20 Amazon gift card. The next chapter provides study findings from all data collection methods described above. I will explain analytic techniques in more detail as I present my findings.

CHAPTER 4. FINDINGS

Data collected from individual interviews, questionnaires, and an online nurse discussion forum work together to answer the four overarching research questions of this study. These questions seek to further understand how nurses communicate in online spaces about their careers, how they describe their work, how other nurses have influenced them throughout their careers, and how strongly they identify with various occupational targets. Overall, these findings indicate that career decisions, communication with other nurses, and occupational identification are all interconnected and influence each other. Additionally, this study explores an under-researched area of nursing communication by examining how nurses communicate in online spaces. This chapter explores these findings as organized by this study's research questions.

Online Nurse Communication

Nurses communicate in online spaces (e.g., Valaitis et al., 2011) but further research is needed to identify ways in which this occurs. Research question one of this study asked: *How do nurses communicate in online spaces about their work?* Questionnaire responses as well as posts in an online nurse discussion forum provide insight into what nurses commonly talk about online.

Participants in online nurse discussion forums answered survey questions regarding how they communicate online. Findings indicated that nurses often had more than one reason for coming to nursing-related subreddits on reddit.com or other nurse discussion forums to speak with other nurses. Of the 379 nurse respondents, 328 (86.5%) come to read what others say on a variety of topics, 200 (52.8%) said they came to get advice, 197 (52%) came to learn more about nursing, 161 (42.5%) give advice, 30 (7.9%) came to find job opportunities, 140 (36.9%) came

to vent or complain about their job, 71 (18.7%) stated they came to meet other nurses, and 21 (5.5%) gave additional reasons such as to relax and laugh by looking at jokes and memes, to gain educational information, to connect with and help other people, and to find out what nursing is like in other parts of the country and world.

354 (93.4%) nurses indicated that they have asked questions on an online nurse discussion forum before. Open ended responses to the question "Can you give an example(s) of the types of questions you ask on the discussion forums?" revealed several themes. Common questions nurses have asked include how to treat patients and other clinical questions, such as "Why a milk and molasses enema is good for geriatric trauma patients." Nurses also ask advice on how to handle certain situations, such as a difficult encounter with a doctor, coworker, or patient. Other questions are from nurses considering furthering their education and seeking advice on certifications and degrees, moving to a different state and curious about policies in that state, wanting to get advice on updating their resume and applying for jobs, and changing units and wondering what they are like (e.g., "What is the good/bad/ugly of working in the NICU?"). There were general questions regarding how to be a better nurse, if others have ever encountered certain experiences, what types of technology they use, or day to day aspects of working (e.g., "Best types of shoes to keep your feet from aching! Scrubs that are easiest to move in.").

331 (87.3%) nurses have admitted to answering questions or replying to other posts in an online nurse discussion forum. A common theme in questions that nurses have answered online pertain to students and new nurses, such as questions about schooling, starting a new job, getting adjusted in a first nursing job, and about considering nursing as a career (e.g., "A lot of nursing students asking if nursing is worth it."). One participant noted, "I like to respond to younger nurses asking for advice. I reply a lot to encourage other nurses because it's a difficult profession

and we need to help each other out." Many nurses answered questions related to the units they work on, both generally (e.g., "What is your job like?") and more specifically (e.g., "On your Behavioral Health Unit, do you allow (policy question related to restrictions in patient care like use of own cellphones or own toothbrush)?"). Nurses also answer questions asking for advice on patients (e.g., "explain how to provide scrotal support using a makeshift sling") and asking to share experiences of situations (e.g., "what was the scariest moment you've experienced as a nurse?"). Finally, nurses answered questions relating to bullying and other coworker issues (e.g., "How can I deal with a scary preceptor?") and how to have work-life balance, practice self-care, and deal with stress and burnout.

Analysis of 600 posts on the r/nursing subreddit between January to March, 2019 mirrors several of the themes indicated by the survey results. Six major themes emerged, which included nurses sharing humorous memes, pictures, and/or jokes ($N = 249$, 41.5%); experiences related to work ($N = 115$, 19.2%); information about their jobs ($N = 75$, 12.5%); venting about frustrations ($N = 67$, 11.2%); asking for or giving advice about work ($N = 48$, 8%); and new students and nurses asking for help related to schooling or their first job as a nurse ($N = 46$, 7.7%). The posts were coded into mutually exclusive categories based on the perceived intent of the post. For example, new students and nurses ask for a lot of advice, but were coded under the "New Nurses" theme to specify advice asked from nurses who indicate they either just started their job or are still in nursing school. Further, several posts coded under "Experiences" were also humorous but were not coded under "Humor" because that theme specifically includes only posts which include a funny meme or photo in which that is the main focus of the post. These themes are described in more detail next.

Humor: "Nursing Be Like That Sometimes"

The most frequent way in which nurses communicate in the most popular nursing subreddit is to spread humor through memes, funny pictures related to work, and jokes about health care or nursing. This humor commonly focuses on aspects that may be stressful in nursing, such as difficult patients and unfair policies. One meme highlights a relatable part of a hospital nurse's day with a photo of a nurse looking through supplies, captioned "When you're chillin' in the supply room just to escape your patients and someone walks in." Another meme focuses on unrealistic expectations on the job, which a cartoon of two thick binders with one labeled "Policy and Procedure Manual" and the other labeled "How We Actually Do Things When We're Really Busy and Short Staffed Manual." Other memes are a little darker, as one shows a picture of people celebrating with party hats, champagne, and blowing party horns and is captioned "When you make it through another day of work without killing yourself."

Another common focus of humorous posts includes making fun of patients for some of the things they do. One meme combines nurses' frustrations of anti-vaccine patients and patients who rely on essential oils to cure them, as shown with a photo of Marie Kondo saying "This one sparks joy" next to the word "Vaccines" and her saying "This one does not spark joy" next to the words "Essential oils." Another meme jokes at patients saying they have a high pain tolerance as the poster writes "I'd give this a 12/10 and usually I have a REALLY high pain tolerance" along with a meme of Morpheus from the movie The Matrix saying "What if I told you your pain tolerance is pretty much the same as everyone else's?"

Experiences: "Has This Ever Happened to You?"

The second most common theme in how nurses communicate online is sharing and asking about experiences on the job. This includes sharing a story of something that happened at work that day. For example, one poster talked about a frightening experience with a patient:

> I was hit in the head repeatedly with a blunt object by one of my patients. He screamed murder at me and I could have gotten much more then a head laceration if one of my coworkers didn't get him off of me. I pressed charges and he was taken to jail shortly after. I supposedly have a case worker who will reach out to me, but right now I would just really like to hear from others who have been through what I'm going through now. I know this is going to be a long road ahead of me. If you would prefer to PM me rather than comment on this thread, please do so. TIA

Another poster included a photo of a syringe going through their glove, just barely missing their finger, and said "Patient got wild during a stick, this was the result." Nurse posters also liked to ask about others' experiences, posting questions like "Tell me your worst family/visitor stories," "Tell me about your first patient death," "What was the weirdest thing you had to deal with," and "What's your worst 'this patient shouldn't be on my unit' story?"

However, nurses shared uplifting and positive experiences as well. One post includes a picture of a toddler with a cheesy grin, captioned "MRW [my reaction when] I get called into the office before 0800…only to be told I got a 25% pay raise!!! Yes, 25%!" Another poster shared a story which she titled "How about an uplifting story for a change of pace…." and said:

> I'm an ICU nurse, most of my patient encounters are managing pumps and vents. Most of my patients are end of life or otherwise trainwrecks. Well tonight I had a lady come in with a C6 dislocation, not sure of mechanism, totally paralyzed. We took her down to

> surgery. Relocated. Plates, screws. Etc. Back up in the ICU, I hear her vent beep, when I go to check on her I lean over the bed, she reaches up with both hands and squeezes my arm. I didnt even know she was awake yet. I look down at her, startled, and she gives me the biggest cheesiest grin, with tears running down her cheeks. Right now shes in there totally entertained. Watching her own toes wiggle.

Similarly, another nurse posted "I cried with a patient for the first time last night" and shared the story of how she or he usually does not cry or even show emotion with patient or coworkers, but when they gave test results to an anxiously awaiting patient and said "When I told her I suspected she was going to have a very good day, she and her husband broke down into tears. And that's when I lost it, too." It was that day in which the nurse recognized, "I've never experienced anything like it before. I doubt I'll forget it for the rest of my life. Today, I am honored and awed to be a nurse."

Information: "What's it Like Where You Work?"

Third, nurses often share and ask about information pertaining to their jobs. Common questions include asking about pay and benefits where others work, requirements for working on specific units, certain policies in their state or organization, and different technologies they use on the job. For example, one nurse asked, "Can you push IV metoprolol on your med/surg floor?" and another asked, "Anyone here actually love working night shift?" Nurse posters also shared information from the news, such as an upcoming nurse strike in NYC related to understaffing (Santus, 2019). This particular story spurred several posts from nurses on r/nursing, including updates on the story and asking other nurses' opinions.

Also included in this theme are opinions of the job. Several nurses asked about other nurses' perspectives on certain topics to get a feel for how things are like where they work. For

example, one poster stated “I work ER. Why are floor admissions such a pain? I’ve never worked the floor so I’d like to get some perspective.” They explained in their post, “I see a lot of memes from floor nurses about getting multiple admissions at once or getting them at bad times and I’m wondering what is it about admissions that make them terrible?” In addition to asking opinions about the NYC nurse strike, posters asked opinions about other stories in the news as well, such as a recent one about a nurse at Vanderbilt charged with reckless homicide after swapping a patient’s medication (Kelman, 2019).

Venting: “End Rant”

The fourth most common way that nurses communicate online is by venting about a number of frustrations in their job, such as patients and families, coworkers, policies, and issues in health care. Although nurses may vent in the form of sharing experiences, this theme differs in that it includes venting about general issues and not one single experience. For example, one nurse posted a screenshot of a patient’s billing summary and said, “In my opinion, this is the worst part about healthcare in the US. The cost it takes to make TPN: $80.94. What is the patient charged? $1232.00.” Another nurse provided an example that is one of many to highlight the ongoing issue of, in the poster’s words, “how management loses loyal employees.” They explain:

> So my job has a list of nurses who have been patiently waiting to move from night shift to days. I am included on that list and have been waiting 9 months now. There’s a waiting list basically or so I thought there was. One of the nurses has been waiting close to two years to go from nights to days and has brought it up to management countless times. She’s s great nurse she’d be fabulous on days. I can say the same for the others on this list as well. Then this travel nurse walks in does her three month assignment and at the end of it gets a full time day position job on day shift... and here we are staffing our night shift

> with a handful of new grads and keeping the people who have been waiting on nights. This isn't the first occurrence of this happening either. To say the least there are some people mad.

Other common topics of nurses venting online include male nurses being teased for being nurses, patients and nurses who are anti-vaccine, unfair workplace conditions, and workplace bullying, which has commonly been called in the nursing field as "nurses eating their young." One nurse came to r/nursing to vent about this very issue in a post titled, "I'm so tired of these old-hag nurses." He continued to explain:

> Title because I've never met a millennial generation nurse that was toxic. Workplace lateral violence is a cancer in the nursing profession. I've been a nurse for only 2 years and I'm sick and tired of having to stick up for myself to older nurses that have an attitude about seemingly everything and the smallest of things. Don't have everything charted perfectly and every single considerable task done by 0700 sharp? Prepare to hear bitching, complaining and talked down to. Every. Time. Despite that they've been a nurse 20+ years and should completely understand it's impossible to be perfect and complete all the tasks assigned to us with the limited resources we have. It is not my fault or responsibility that you are miserable and hate your job, and that you're too one dimensional to consider a speciality change and god forbid even a career change. Being toxic to coworkers is unprofessional and has no place in healthcare. There are little professions WELL KNOWN for unprofessionalism in regard to lateral violence being COMMON. Nursing deserves better, or at least I know that I sure deserve better. The American Nursing Association has addressed workplace bullying as a major problem within the profession. The non-negotiable code of ethics published by the ANA states

> that to be considered a professional nurse we must work to create positive work environments and treat each other with respect.

Many times, nurses come to reddit to just vent about aspects of their work but sometimes this is accompanied with asking for advice, which is described next.

Advice: "What Do I Do?"

Fifth, nurses come to the r/nursing subreddit to ask advice on how to handle a situation with a patient either socially or for treatment, how to deal with a difficult coworker, and whether or not they should switch units in their hospital. For example, one nurse stated, "I want to leave nursing, but I'm not sure where to go." They describe their current position and how, in the three years that they have been a nurse, is "still doing the same thing" and not sure of where to find better opportunities. The post concludes with the poster asking "Where do nurses go when they leave the bedside?" Other posts asking for advice include "Nightshifters, how do you switch to being awake during the say when you're off?" and "Inserting IVs without leakage," as well as some questions asking how to have a healthy work-life balance.

Additionally, some nurses come to r/nursing to *give* advice that they feel will be helpful to others. One nurse shared some valuable advice to others who are feeling burned out:

> I hope to help at least one nurse with this post. 7 months ago I was on a telemetry/med surg floor. It was my first job out of school and all I've ever known is working on the floor, as I was a nurse aide for 3 years on a med surg floor. I thought I wanted to eventually do ER. I lasted about 2 years before my mental health SERIOUSLY started going down the drain, mostly from my job. The constant understaffing, the specific toxic older nurses, the abusive patients and family members, the "customer service" we're

> expected to provide... all accumulated and had me over the edge with stress to where I was thinking about ending my life.
>
> Fast forward, I have been lucky enough to have landed a job in an operating room at a major academic medical center. I've never been happier in my career. My burnout has completely gone away (for now). I genuinely look forward to going to work! To all the floor (or any) nurses that might be in the same spot I was in, please change specialities. It will dramatically improve your life and happiness!! There's so many different things we can do that's not med surg, do not stay in it if you're unhappy.

Another nurse took to reddit to share advice on what kind of shoes to wear on the job to prevent feet problems in the future.

Alternatively, sometimes non-nurses enter the nursing subreddits to seek advice on working with nurses. For example, one patient was preparing for a five-day stay at the hospital and wanted to know how to be a "good patient" and wanted to bring in snacks for the nurses caring for her. Some other patients came to seek advice about certain medical conditions, as one poster asked, "Does this require immediate attention or can it wait til Monday morning for the GP [General Practitioner]?" Another poster asked "Do you have any tips for me as I seek to interact more meaningfully with the nurses on my floor?" as a chaplain who works with nurses.

New Nurses: "I'm New Here"

Finally, and as some survey participants indicated above, new nurses and nursing students go online to ask questions of more seasoned nurses. All instances where a poster had asked for advice on getting through nursing school or their first job as a nurse, how to do a procedure for the first time, and whether or not they should get a nursing degree were included in this theme. Several potential nurses came to r/nursing to find out more of what it would be like to

go through nursing school and become a nurse. Posts included questions such as “Was nursing school hard for you?,” “Why did you choose nursing and are you happy?,” “What does living on a nurse’s salary look like?” One nursing student expressed his concerns based on what he had read online and said:

> Does anyone here love their job? Or even love nursing?... I am a 23 year old male going into nursing..About a year left… It seems like everyone hates it, and I read so many complains here also.. It gets me very worried about my future. Any input?

New nurses also go online to seek input from more seasoned nurses. Many new nurses seem to struggle with starting IVs when they first begin, as one poster explained her troubles with getting the catheter to advance. Another new nurse asked, “Are there any good charts or resources on IV medication administration? When you can use the medication port, what rate to not put through an IV?” Others had questions related to first time experiences, such as a nurse who experienced their first code, detailed the situation, and said “was wondering what you guys thought about this, and how you guys respond to codes.” New nurses also come to share good news such as getting their BSN degree or, as one nurse expressed:

> I wanted to share my happiness with this community. I passed my program today and now I have to prepare for NCLEX!! Soon I’ll be a licensed nurse. But now..today I’m a graduated student. I’m safe, I’m competent and I want other out there to know you can do it too!

As shown above, nurses do use online spaces to communicate in a variety of ways. Some of these findings align with extant research which suggests that nurses go online to share stories (Valaitis et al., 2011), share knowledge (Brooks & Scott, 2006), and obtain job information (Morris, 2005). However, findings of the current study uniquely highlight the frequent use of

humor as a way to unwind about certain struggles on the job, as well as using online spaces to discuss career decisions as shown in new nurses and nursing students seeking information about furthering a career in nursing.

What it Means to be a Nurse

Nurses describe their work and the profession as a whole in a variety of ways. Research question two asked: *How do nurses talk about what it means to be a nurse?* Data collected through individual interviews answer this question. A number of themes emerged when nurse participants were asked to talk about their jobs. These themes include nurses describing what the nursing profession is like and what it is like to be a nurse, trends and issues in nursing and how it needs to change in the future, why there is shortage and turnover in the profession, and moments which have defined their careers. Additionally, I asked nurse participants specific questions to further understand their work and I want to highlight four more themes because they provide insight into the various ways in which nurses make sense of their work and also provide information which may be useful for both theory and practice. These themes include expectations of their job before they started, how they talk about their own career trajectories, whether they see nursing as a "job" or "career," and advice they would give to future nurses.

What Nursing is Really Like

Nurse interview participants were asked to describe the nursing profession and what it is like to be a nurse. Three overarching themes emerged from their descriptions, which include the nursing profession being diverse with many different opportunities; being difficult but rewarding; and nurses as respected, trusted, patient advocates. These three themes are provided with examples below.

Nursing is diverse

Nearly every nurse participant described the profession as being uniquely diverse compared to other professions. Carmen, a pediatric hospital nurse, pointed out that even more "broad and varied" than most people think:

> I think when people think of what a nurse is, they're thinking of nurses who work in hospitals, but the reality is that while that is probably where at least a third of nurse's work, there's this whole other world of outpatient and home based like medicine. Telemedicine and things like that where nurses can work. And so I think that we, our training is very general, but then you know, most of what we actually learn and need to use is very much like on the job based. So there's these silos of knowledge that exist in like every different specialty or in every different office even.

Indeed, even within the same office there are nurses who have much different roles. Sienna, who has spent the last six of her 13 years as a nurse working in an endocrinology office, talked about how her role changed from an RN to becoming an NP:

> My answer would be different as an RN than as an NP. As an RN, I would say that being a nurse is kind of being with people at their toughest moments or even their most exciting moments depending on what kind of nursing or by seeing people at their worst and just helping them through a time that is critical for them as an RN. So then as an NP I would say what it's like to be a nurse is to, in my particular role is to encourage and help people be the healthiest that they can be. My roles were very, very different from RN to NP, so I was in the emergency room as an RN and now I'm in more of a health promotion type of position. So very different, very different aspects of nursing.

Kim, a nurse of 41 years, makes a similar point but highlights that all nurses share something in common:

> Whether you be a registered nurse or a nurse practitioner or you're teaching or you're in administration, it is making a connection with patients, establishing trust so that you can both work together to get them where they want to go.

She added that it took her years to fully understand what a nurse was or what defines a nurse, and this patient connection is "the most important job nurses do really" and is something that normally does not exist in other areas of health care.

Another way in which nursing is diverse is that there is some nursing job that can appeal to everyone. Rachel, currently working as a nurse surveyor but has also worked in a hospital and has taught nursing, said "it's a nice thing about nursing is that it's so broad that there's a job for every personality type." She recalled a time when she was burned out from working in nursing administration and needed a break. To her, she ironically found that break as being a floor nurse because she said "I don't want to have to think any more than just taking care of my patient." Others may find bedside care less appealing, and Sienna points out

> You can be a nurse and never touch a person. You can be a nurse and, you know, be doing critical care or you can work in an office or you can be in anesthesiology or you can be a nurse practitioner or a clinical nurse specialist where you're doing more of the research and quality practice. There's just unlimited possibilities in nursing. So whether you're at the bedside caring for someone or whether you're working behind the scenes to make sure that everybody's getting what they need from clinically or informatics or whatever. There's just this unlimited opportunity in nursing. Amazing.

She adds that “the nice thing about nursing is you’ll never be without a job unless you don’t want to have a job.” She recalls her own experience working in multiple hospitals and having no difficulty finding work as she traveled with her husband. Monica, who currently works as a clinical assistant professor of nursing, gives a few examples of nurse friends and their various positions in the profession:

> It's so broad and that's one of the best things about it…You could have so many different career paths and that's kind of amazing. You could do bedside nursing with any population from neonates through geriatrics. You could do outpatient nursing and almost all of those things. You could do travel nursing. I have a friend who was a cruise ship nurse, she administers dialysis on cruise ships…You can do school nursing. I have another friend who hated bedside nursing by her senior year, so she's a lobbyist and works as a lobbyist for nursing organizations because she is a nurse. You could get advanced degrees, you could do education, you could be a school nurse. You could be a home health nurse. Like there's just so many options that you have open to you and very few professions give you that flexibility in my experience.

Several other nurses mirrored these sentiments by sharing their varied experiences in their careers so far. Nearly all participants had made several changes due to family needs or disliking the job they were in but eventually found an area of nursing which suited their desires.

Nursing is difficult but rewarding

Nurses also commonly described the profession as difficult but rewarding. In nurse Carlos’s words, “it can be tumultuous and hectic and chaotic at ties, but that it’s very rewarding.” Other nurses described a number of reasons what they find most difficult about nursing. For instance, cardiac ICU nurse Lindsay says:

> The emotional and physical toll. Like you're on your feet for 12 hours, you pull up people in bed, you get them up to the chair, you put them back in bed, you walk them, you know, you're constantly moving and on your feet and you're so tired by the end of the day. So physically it takes a toll and then emotionally it can take a toll. Just I've become very jaded, I have a different perspective on life and death and what I think like how people should die.

Nurse Carmen thinks the most difficult part of nursing is the drama because "You work with mostly women and other doctors and I think it's pretty safe to say that whenever you're on a team, no matter what your role is, there's gonna be friction." Additionally, Sharla, a nurse of ten years, adds that nursing is challenging in that it requires a lot of critical thinking skills:

> You got to be pretty darn on it and have a little bit of smarts to be a nurse. you have to think critically. You have to be reactionary. You know, you walk in and you see a patient and they are breathing three breaths a minute, you know how to react to that.

However, despite nursing being one of the most stressful professions, it is often thought of as the most rewarding. Tiffany, a neuro trauma nurse for nine years, says

> Nursing is something that I absolutely love doing. It's really hard work. it's mentally, physically, and emotionally challenging every second, but it's rewarding and I wouldn't trade it for anything. And I've always said that even if I wasn't compensated with money…it would still be something I would do.

Stephanie, a cardiothoracic nurse, not only sees nursing as rewarding but as a privilege:

> I think a huge part of what we do is so intimate with people. I've seen a lot of patients where they don't want their kids coming to see them, they don't want their grandkids coming to see them, they don't want people seeing them in the way that they are at the

> hospital and a lot of times their worst days. And I think it's really cool that they trust us just to be with them and take care of them. And a lot of the patients that I see are older, and I think it's really cool to care for a population that's made the world that I'm in…So I just think it's a huge privilege to be able to take care of people when they're at their worst and that they trust me, of all people. I think that's super cool.

Nurses are respected, trusted, patient advocates

As mentioned above, nurses value the trust they receive from patients in offering them care. Nurse Samantha notes that although nursing is disjointed because of the various levels of entry into practice, it still remains "consistently very highly valued from the public's perspective, and trustworthy and high ethical." Nurse Ashley adds that in her 29 years as a nurse, she frequently receives respect in public places when she wears her nurse uniform and when she tells people she is a nurse. Further, several participants stated that not only are nurses trusted and respected, but they are a critical part of health care. Nurse Tanisha states that "the nursing team is the first and front line for the medical care team" because

> No matter, you know pharmacy, radiology, physicians, they all go to a nurse because a nurse will give patient direct care. You know, like a physician, they may gather a general idea from a nursing note but they may call us for phone call. But the pharmacy, they may get medication but we still have to make sure everything's okay, to educate the patient on how to take the medication.

Jamie adds that "I don't think the medical profession could survive without us…because we have the holistic approach to the patient. Whereas we're not only treating the disease, we're treating the whole person." By this she provides an example of if a patient were diagnosed with cancer,

the nurse would also be considering how that patient can get to and from treatment, if they have support systems in place, and what their family dynamics are like.

Participants also commonly referred to nurses as advocates. Amelia, a pediatric progressive care unit nurse on night shift, describes her role during each shift:

> I'm with the patient for 12 hours and I am their person. I am there to meet their needs to make them feel better, to make sure they get all their treatments and make sure that they are advocated for. Sometimes, the doctors will just see little snippets…So especially overnight, like I am there to call the doctor and say like, 'this is what's going on, I think we need to do this…' So it's just probably caring and advocacy would be two key words.

Dave, who has been a nurse for 22 years, adds that nurses are not just caring people but "they know when to really push hard towards getting something taken care of for somebody that is in a needy situation." These sentiments highlight the holistic care and commitment that nurses commonly feel in their work. This concept is something that Sophia, an RN who earned her PhD in nursing, said is discussed in the classroom as well:

> So I'll tell you what is a nurse. This is a question we spend time on in a philosophy course an entire semester thinking about. And I really truly believe nurses are intermediaries. We're there to pull together all the fragmented pieces to provide a whole experience for the patient. So while part of it is caregiving, a lot of that caregiving can be done by other people that doesn't require a nurse. What requires a nurse is to be able to pull it all together and then to translate. So to be able to recognize when the doctor needs to come in, be able to translate what the doctor has said, be able to make the connection between the doctor and the social worker or the pharmacist or whoever else needs to be there so

> that the patient gets the appropriate care. So I really firmly believe that's the role of the nurse, that intermediary role, the glue basically for the patient care.

So as nurses are often seen as advocates, intermediaries, and having the skills to think through a situation holistically, one word that a nurse may not want to be referred to as is an "angel." Nurse Monica states

> There's like in the media, nurses are angels, they're such angels, they're angels on earth. I can't stand that message because I don't want the angel nurse. I want the smart nurse. I want the nurse who's going to catch my physician's mistake. That's the nurse I want. If she's nice, bonus, but I want the smart nurse. And I think that nurses being kind overshadows nurses' intelligence and skill when I see media portrayals of nursing.

Across the board, whether it be from nurses currently working bedside or in the university and everywhere in between, nurses do seem to stand united in how they would describe the nursing profession.

The Trajectory of Nursing

Another common way in which nurses talk about the profession is in terms of the issues it currently faces and how it needs to change into the future. Some of these issues include the need to become more cohesive, establish a unified identity, establish clear degree requirements and levels of entry, change policies including on patient care, and transform harmful and outdated views of nurses.

The need for cohesiveness

A concern that nurse participants stated is that the nursing profession is disjointed and needs to become more cohesive in many ways, including several of the themes described below such as establishing a clear identity and entry level degree requirements. Nurse Sophia says

> So nursing is the largest workforce in the country. There are more nurses than any other specific career. They are also probably the most disorganized and disjointed. There are still three levels of education that qualify you to sit for the licensing exam. We do have a national licensing exam that is accepted everywhere. However, state licenses do not transfer from one state to the next…[This issue] has been around for 50 years and we still can't solve it…You can have the best evidence, the best research, showing some things the right ways and you will run into an older generation nurse who says, 'well, in my practice it's always worked for me and I've always done it this way.' And so I don't know how pervasive that is in other industries, but I know it is a huge hurdle in nursing.

Similarly, nurse Samantha notes that even though nursing is very broad, which so many nurses highlight as a positive side of the profession as discussed in the previous theme, it is also very disjointed in terms of health policy advocacy. She says, "I think about how powerful nurses could be if we were more collective in our actions. And so I see some of that stuff happening but not to the extent that it should." Further, she also identifies multiple entry levels into practice as something that confuses the public, as "patients don't know what the differences are per se and what one can do versus somebody else." Heather, currently a VP within a hospital, agrees that

> I don't think we're as cohesive as we could be. I think also nursing—this is not going to be well thought of—but sometimes nursing we want to be part and integral to the interprofessional team and acknowledged as members and leaders. But then on different

> things we want to be separate and isolated and not, you know, 'this is a nursing issue, not a health care issue,' those kinds of things. So I think we sometimes have a little bit of a problem with our image.

As mentioned, a lack of cohesiveness within the nursing profession includes disagreements on what should be required as a point of entry into nursing not only between states but also even within the same organization. One consequence of this, as Samantha mentioned, is that patients and the public as a whole may be confused as it is unclear of what the identity of nursing is at times. The issue of establishing a unified identity is described more next.

Establishing a unified identity

As noted above, nurses believe that the profession as a whole has a problem with the identity of nursing. This differs from personal identifications that nurses have within their work team, organization, and profession which I describe in a later research question, but it does center on the overall identity of the nursing profession and how others see it. One way in which the profession struggles with its identity is in terms of where it fits within health care. Nurse Jamie states

> We have our own separate body of knowledge, we have our own set of skills and I see us as unique and I've seen us as a profession that is continually striving to identify itself in the medical community, which I think is a big mistake because there's nothing—I mean we have medical components of our profession that's like passing medicine or doing procedures with the physician, but we're not medicine. We're an adjunct of medicine…

As mentioned previously, a major reason for the struggle in creating an identity for the nursing profession is due in part to the multiple levels of entry. Nurse Heidi clarifies this further by explaining that although nurses work very hard and are one of the most trusted professions,

> so many people don't know what we do and…there's so many points of entry. You can get a two year degree and be an RN, you can get a four, you can go straight to master's, there's so many points of entry that we are really crappy at making a good identity for ourselves…We can't even define who we are as a group, but I think so many of us feel so strongly about this profession we chose, but as a group we just can't get our act together to kind of bubble define what we are. We're kind of everything and I think that's to our detriment because then nobody else knows who we are.

She adds that this may hinder nurses from having "more of a voice in decisions" within health care because they are not good at communicating their vision or even agreeing upon a unified vision. Next, I will further describe another reason nurses mentioned as part of the problem in establishing cohesiveness or a unified identity, which is having multiple levels to entry in nursing.

Nursing entry level degree requirements

A topic that many nurses are passionate about when talking about issues that they would like to see change relates to the varied and unclear degree delineations within nursing. A common opinion is shown by Jamie's comment that "in order for us to be recognized as a profession, we need that four year degree." She herself started out with an associate's degree and worked for two years before going back for her bachelor's, so she understands that this option still exists in order to get nurses into the workforce, but she argues, "I feel about getting your bachelor's is it's those courses…teach you to critically think…it makes you a more rounded person and makes you understand and you approach things differently, more holistically, and seeing the bigger picture…" Nurse Dave noticed something similar when he worked in an organization which did not require a minimum bachelor's degree. He says

> Even before I knew what [coworkers'] entry level under practice was, I could tell by their professionalism and that they didn't have a baccalaureate or higher degree and it really bugged me. I thought that their professionalism was lower. I can't necessarily sit there and say that the care for the patient was worse. But I think if your professionalism's lower, there's always that possibility and you're definitely not doing the profession any favors…my opinion is until we change that, the entry level practices, at least the baccalaureate level and then we're not going to see a lot of change.

Although many nurses not only recommend to new nurses that they further their education but that the profession itself remove the possibility altogether of entering with only an associate's degree, this does not come without additional challenges. One of these challenges includes the existing problem of nurse shortage across the country. As Sienna, a nurse with an MSN, notes

> They keep saying that they're going to require a bachelor's for entry level nursing. Well, unless we can get rid of the shortage of nurses, we're not ever going to be able to require a bachelor's for entry level nursing. It's not gonna happen…I'm making the exact same money working the exact same hours in the exact same position as a nurse with a two year degree, or sometimes the same as an LPN or an MA. And so without having that… entry level is going to be a bachelor's and there's going to be a distinct difference between what an MA does and what an RN does…it makes it more difficult, I think, to kind of pay accordingly to really treat your nurses how they should be treated. Because there's not a standard for degrees or anything like that.

In addition to the very real issue of existing nurse shortage hindering the ability to raise the minimum required education needed to enter practice, nurse Jessica highlights another facet of the problem in that more highly educated nurses are less likely to stay working on the floor:

> I am a little bit concerned with nursing in general right now because I think that they're producing nurses to work in hospitals as floor nurses, but the quality of students that they get at nursing schools now, most nursing schools is very high because the number of clinical spots is small. And so, you know, sort of similar to medical school, they get… a really high quality of student and a lot of those students are not going to stay as RNs. They're going to go ahead and get other training…one of the things that I think is immediately an issue is that a lot of those new RNs are not going to stay as RNs for more than a couple of years. They're just too, bright. I mean floor nurses are great. But you know, it doesn't take a person that has a 4.9 average to be a floor nurse...

This debate about whether changing the level of entry would be more helpful or hurtful to the nursing profession is one example of the difficulty nurses face with establishing a shared vision and cohesive identity.

Policies and patient care

One issue in nursing that was also communicated in online spaces, as illustrated from the first research question findings, is the need for certain policies to change. One such policy relates to how insurance reimburses care from nurses. Nurse practitioner Sienna explains how her care is covered in her office:

> I think there's still some lag in seeing nurse practitioners as providers from insurance, Insurance only reimburses us 80 percent of what they would reimburse a doctor, but yet we're doing the exact same thing that a doctor would be doing. And in a lot of cases in the place of where you can't get a doctor to go, we're willing to go and we're doing it, which is exactly what I'm doing. They have been trying to get a doctor in my position for two years and they finally said, ‘well, let's get a nurse practitioner instead until we can

> get a doctor in here.' And so basically I'm functioning as a doctor, but only getting compensated—well, the organization's only getting compensated 80 percent of what I would be as a doctor…It's holding us back from being able to really take care of patients the way that they need to be taken care of. And I know that they've tried to pass legislature to have nurse practitioners be able to practice independently without a collaborating physician. And it got shot down two years ago and I'm sure it'll come back up but, just to see more independence, I guess. And it's kind of organizational, not just legal, it's not just what the law says. And like within my organization they say that a doctor has to see the patient the first and last time, the first and last day that they're in the hospital. Otherwise I would be able to consult on patients in the hospital. But that's what my organization says, even though there's no law. So, you know, that's holding us back from being able to take care of patients in the hospital. So just different things like that that, you know, to kind of bring, bring the organization up to support nurse practitioners better, not just in compensation but just in allowing us to practice within our scope of practice fully.

Sienna not only provides an example of how insurance hinders nurses from providing effective patient care but also how organizations have individual policies surrounding how nurses see patients, which limits the ability nurses have. Other hindrances to patient care have also been noted. For example, Sandra states that advances in technology are contributing to "making us farther from the patient." Similarly, Tiffany feels that charting is getting in the way of her patient care. She notes

> My least favorite part of my job is the bureaucracy of the hospital and charting, you know, we're expected to chart, chart, chart, and there's really no time to do that if you're

> providing the kind of care that I feel should be given. We have three to four patients [per nurse] on my current unit and they are all very acute. We upgrade patients to the ICU on a weekly basis if not more often than that. So we need to be focused on what's going on and you know, how our patients are and it's hard to do that when we have to chart and then of course the management is like, get out on time, take your lunch, throughput, you know, getting people through and downgraded, discharged in a timely fashion. And you know, a lot of that's out of our hands. We can't, but they expect us to still do it.

The change over time to focus on non-patient aspects of health care is seen by seasoned nurses who believe administrators see patients more as "customers" now. Erica describes the changes over her 25 years as a nurse:

> I've seen things change with the way that hospitals are corporatized… and so it's more about the bottom line and not about patient safety or, it definitely is about patient satisfaction though. And I have a hard time with that because unfortunately I feel like nurses are being burned out because they come in and the patient's family will dictate a lot of the care as opposed to the doc… [or] a nurse who has tons of experience and knows what is usually best unfortunately. They're not respected for their knowledge. It's more what people are finding on the Google Internet search… it just pulls on the heartstrings a lot because [nurses] feel like they can't do their job without a patient coming back and complaining…I would say that 25 years ago, it was kinda like, 'oh well the nurse told me to do that so I should do that.' And nurses were probably a little more respected. But as I say now it's all about the bottom line…And so nurses are like, not only is this a hard job, but these patients are like screaming, yelling, you know, and I'm not being supported by the people, like the corporation that should be supporting me.

Nurses not only feel like they have lost respect in this manner, but even more upsetting to them is that quality of patient care has decreased. This decrease is not only due to increased demands on time charting and being away from the bedside but also with the push for expensive treatments that profit the hospital but may not necessarily be best for the patient. For example, Stephanie talks about how her hospital does many advanced procedures but she sees ways in which this is not always a good thing:

> So [hospital] is a huge hospital and it does do super cool things, but I also see the downside of it because they do a lot of things that other hospitals don't do. I think sometimes quality of life does suffer. I do see a lot of patients that are in their late eighties and nineties getting surgeries that sometimes I think it would almost be better to let them live out their quality of life. Maybe for a couple of years rather than having a surgery that might prolong it for five. But it's kinda one of those things that like, I see sometimes they're dragging on their lives with all these surgeries. But their quality of life isn't getting any better… So I think that's one of the hardest parts, like morally that it's treaded on me a couple times just like seeing that.

Similarly, Tina offers a vivid example of how one of her former hospitals did this, which contributed to her leaving the organization:

> At this facility it seemed like there was a lot of really futile care. Even all of the nursing staff knew that there was, like the patient, there was no way that the patient was going to make it no matter what we did, it seemed like sometimes we keep these people on VA ECMO (veno-arterial extracorporeal membrane oxygenation) for like two months and we were just like torturing a dead body and we knew and we would watch these people like rot from the inside and we had huge ethical problems with it. And the physicians refuse

> to have the conversations with the family because we could like artificially completely keep them alive because it's complete heart lung bypass. So like they cannot die on it… It's not possible for them to die physically. And that was like gut wrenching. And so that really like burned me out for a while, like I needed a break from that… I enjoyed taking care of my patients. I just did not enjoy feeling powerless in those situations and not being able to say I don't think that this is beneficial to the patient at this point anymore in the situation…

The adoption of this type of care is becoming more prevalent, according to nurse participants, which is taking away from a holistic or "whole hearted" level of care in which they have described to be unique to the nursing profession. Because of this and other issues identified above, nurses perceive that the changing requirements of their work are heading in a direction opposite of that which aligns with their values as a nurse.

Transforming outdated views of nurses

Lastly, nurses identified that one important change that needs to occur within the profession as it moves forward is to update some traditional ideas about nurses. Even though participants characterized nurses as being a respected profession, this respect is mostly noted in social situations outside of work. Ironically, nurses do not identify that same respect pervading the hospital walls, and in fact note a lack of respect and voice within organizational decision making. In some ways, the ideologies of the early colonial American nurse still live on today. Nurse Dave states, "We've kind of come up with the thought process that maybe because [nursing] started off as a female dominated profession, which it still is, but maybe that handmaiden type of thought process hasn't gone away from society." He notes that because of the thought process, "we're stuck being kind of at the mercy of more people than what we would

really care for." This image of nursing is even displayed in the media which further contributes to the lack of respect in regard to acknowledging nurses' intelligence and independence. Nurse Kim makes this point as she reflects on what frustrates her the most:

> A lack of respect, preconceived notions of what nurses were, you know, how the media portrayed nursing. That kind of stuff got to me more once I was a nurse and I was frustrated by it… You go back and look at some of the shows of the seventies. The nurses still wearing the little white uniform with the cap and it's short, you know, so that part of it was very frustrating because I saw some really intelligent people working within nursing and not getting the respect that they deserved. That was the negativity and the question of 'What? Well, you're smart enough. Why didn't you become a doctor?' Well you better be glad I didn't become a doctor because you wouldn't have a smart nurse here taking care of you, would you? I wanted to say it that way but I never did.

However, sometimes nurses hegemonically contribute to these outdated views. This occurs through bullying, which will be discussed in the next section, but also through seasoned nurses instructing new nurses to continue in traditional ways. Nurse Natasha, currently a nursing professor, explains this culture:

> I think by listening to some of my colleagues, even in school nursing, I think the older generations feel like until you have so much experience, whatever the number is they choose to throw out, you shouldn't go back to grad school or until you have so much experience you shouldn't work outpatient. And so I just think we just have sort of these rules in our minds that are false. And so I think we're sort of beating up our own young nurses because we think they need to do with the way we did it.

She recalls a recent example of one of her students who almost left nursing school because she felt she was not good enough because she did not want to work in a hospital. One of the reasons for the high level of turnover in nursing is the stress associated with working at the hospital bedside, and this may partially be due to young nurses feeling that they are not able to leave bedside practice or that it is the only option for them, and they may end up leaving the profession altogether.

Additionally, the outdated ideologies of nurses prevent them from having a voice within the medical community. Several nurse participants note that although they have such an important role and have so much knowledge about patient care, they are not recognized as they should be. Nurse Carmen explains

> So I get some people saying [nursing] being very lowly, it's viewed as having very little power, but I do think that there is a burgeoning amount of influence that this profession will have in the future simply because there will not be enough doctors to take care of everybody's needs. So I think that's really where nurses can come in and kind of try to tie everything together.

However, one way in which this influence will be brought forward is in part to support from leadership, which nurse Vanessa describes:

> I think that the main thing for nurses that will stay in and keep going is that they have to have leadership support. They have to have leadership understanding and I think that it's important that if you don't understand what I do, it's important for me to make sure I take the time to help you learn what I do…Just having that support and every once in awhile it'll be nice to hear 'you're doing a good job.' It's not always about money, it's about being appreciated.

As Vanessa points out, it is partially up to the nurse to communicate the knowledge to others to help them to understand. Carmen also speaks to this need to communicate more clearly to others and provides a frightening example of when this is especially necessary:

> [At previous nursing jobs] often I felt like I had these grand visions, what I wanted to do with something and I can just tell that nothing was gonna change. So I think that nurses have to establish a sense of urgency and figure out how do you communicate those needs to coworkers and to your managers. If you feel confident enough in yourself to approach that manager and tell them this is a problem and it has to change or a patient's going to die, they're not going to believe that the same way they will if you say, 'you know what, I looked at this problem and I had a patient who almost died.' You know, there was an incident in our clinic a couple of weeks ago. We had a baby that almost died like in the clinic in front of us, which is super rare because it's an outpatient clinic. This kid was actively having a seizure and you know, I was the nurse in the room and I couldn't find the blue bag to like help this child start breathing again. You know, so I'm here with the doctor and the doctor is telling me this kid needs oxygen, let's get that going, I need you to get me a blue bag and I'm standing here going, okay, I know what a blue bag is. Where is it? You know, it took 10 minutes. It felt like forever to try to find the thing. And thankfully right at that moment, like an EMT came in and we were able to get that kid going right away, that was the EMT like literally saved the day and I went to my manager and I told them like this is the problem and I filed an incident report and the providers were really upset about that whole scenario but the kid lived, you know, and our manager has been so responsive to that, like trying to make sure everybody knows where all those things are. That is like the best case scenario and sometimes those like crisis situations, if

> you work with managers who don't seem to care or they're so overstressed by their problems, you take that kind of thing to them, they don't necessarily see that it's a problem. You just have to figure out how to craft that message to really get their attention.

In this example, there was a clear issue with making sure all equipment were easily accessible in case of an emergency. These situations may make it easier for nurses to speak up to initiate change. However, as seen in other examples above, issues like negative or outdated views of nurses may be more difficult because they have endured throughout time and in some ways are even perpetuated by other nurses.

Shortage and Turnover in Nursing

Shortage and turnover have been well documented as consistent issues in nursing (Halperin & Mashiach-Eizenberg, 2014). With the exception of a short period of time in the early 2000's, nurse participants have noted that it has always been easy to find nursing jobs because of frequent openings due to organizations being unable to retain nurses long-term. Some reasons for this as mentioned by nurse participants include the baby boomer generation retiring as well as nursing programs having limits on the number of students they can accept. However, when asked what they thought were the major reasons for shortage and turnover in nursing, participants cited three reasons: incivility and bullying, unrealistic expectations of the job before entering, and stress and burnout.

Incivility and bullying

A topic that arose in every single nurse interview without prompt is incivility and bullying in nursing. Interestingly, almost every nurse specifically used the term "nurses eat their

young." This is not a new term; the research literature contains both quantitative and qualitative studies of this phenomenon (e.g., Rowe & Sherlock, 2005; Simons & Mawn, 2010). This issue is also often referred to as "horizontal violence" (McKenna, Smith, Poole, & Coverdale, 2003). Nurse Vanessa notes that this is such a problem that there are a number of campaigns with titles such as "Nurses support their young" to change this culture. She recalls being treated badly when she became a nurse over 30 years ago:

> I went in with 'oh they're gonna be grateful, new nurse, new energy' and no, they didn't like me and you don't know anything and you should know everything because you just got out of school but you don't know anything and I mean it's almost like going through that adolescence again, you didn't know what to think and it's still 30 some years later we're still dealing with incivility and bullying…We're losing a lot of good nurses. Our millennials are like, 'yeah, I don't have to put up with this. I'm out of here'… We have lost more good nurses in the six years that I've been here than I can count… [Nurses who bully are] like, 'well I went through hell, so they're going to go through it.' I'm like, no, no, no. No, no, no. You should not let that to happen because you did.

Nurse Andrea points out the irony of incivility in such a caring profession and says, "…It's kind of ironic for a profession that really is based on caring and trying to take care of people. But we could do that with our patients, but we don't do that with ourselves."

Nurses provide several reasons why they think incivility exists in nursing. As Vanessa mentioned above, some nurses propagate this behavior because they were recipients of it when they first started. Heather explains, "I think there are some older nurses and nurses that feel like it's kind of the hazing that has to happen." She says even though organizations are working more to reduce bullying in nursing, it still exists. In fact, Natasha states "There's definitely like the

older school way of thinking and I feel like the whole nurses eat their young idea is very much still a thing and I think that that's always going to be a thing because I feel like nurses are for the most part some of your more independent people." Additionally, Sophia believes the bullying is gendered and describes

> Because nursing is a heavily female dominated profession and I hate saying this as a woman, but the reality is women keep other women down… I've honestly never been treated worse in an organization than by other women in leadership roles.

This may be another example of the hegemonic behavior in nursing, also illustrated above with nurses contributing to some traditional and harmful views of nursing. Another reason for incivility in nursing is because of trickle down from doctors and others, as Monica describes:

> I think it all comes down to power differentials and I think that when nurses are made to feel powerless, they try to disempower people below them and you don't have to. We can just try to raise everybody up. What is it, 'a rising tide lifts all boats' or something. So I like fostering new nurses. I try very hard not to [bully them].

These examples indicate that nurses may feel compelled to bully younger or newer nurses for a number of reasons which stem from themes identified previously, such as harmful traditional views and behaviors that have endured through time as well as lack of respect or support from others. This behavior is often not anticipated by new nurses, as Vanessa had mentioned when she first started and thought everyone would be grateful for a new nurse in the organization. Further elaboration on unrealistic expectations is described next.

Unrealistic expectations

Another reason for nurses leaving the profession is due to having unrealistic expectations of what nursing will be like, or rather, not anticipating all the struggles that exist on the job.

Something that nurse participants frequently mentioned is that nursing is much more difficult than most nursing students expect. Andrea says this is called the "academic to practice gap" and says that, as a nursing professor,

> We're just so limited on what we can teach them while they're here. We give them the basics but the realities of the situation is they have maybe one or maybe two patients at most when they're doing clinicals and taking care of that and then they get into a unit where they may have five or six patients and now all of a sudden they're instead of working underneath a nurse or a faculty member, they're on their own.

Heather describes this experience further and why new nurses are leaving the profession:

> When [students] choose nursing and they realize, 'Wow, this really isn't what I wanted to do.' I think number one is that in schools of nursing, and not all but in lots of schools of nursing, you know, as a senior getting your baccalaureate degree, you've been out there and you've been taking care of, you know, maybe six patients, but having somebody with oversight of what's going on and you know, in a well-controlled environment, let me put it that way. Not making a lot of your own critical decision making, but having people to help you, granted. Then they get out into the reality of what a hospital is like, which most nurses will go into a hospital setting to get the experience, go through their orientation and then, you know, thrown into settings where there is nobody to really help them out and then maybe taking eight patients that are seriously ill and it's a tough world out there as well as taking care of the computer… We should be taking care of patients, but we're nursing the computer more than anything else. I think they're thrown into a whole different world of not what they expected and not what they experienced when they were

> in nursing school. Because once you get out there and you're a nurse, yes, you're on a floor and there's other nurses there but they're just as busy and sometimes the new nurse doesn't feel like they can ask questions because they'll be viewed as being less of a nurse at that point in time.

She adds that even though there are some organizations trying to change that, this is still a huge issue because new nurses are not used to having so many patients, especially on their own. Additionally, new nurses may be put into units that they are not familiar with, which Vanessa says she often hears being referred to as "being thrown to the wolves." She recalls when she became a nurse 32 years ago, "you went to med-surg and you got some foundation." However, she says because of shortage, new nurses of today are being placed in other areas such as the intensive care unit (ICU), operating room (OR), emergency room (ER), pediatrics, mental health recovery, or others.

In addition to nursing being more difficult than new nurses may have expected, there are certain ways they expect the job to be which often is inaccurate or reality. For example, Monica describes the feeling of learning that the job does not match anticipations:

> I think a lot of nurses go into it wanting to take care of patients, wanting to help people, wanting to spend time, wanting to be that reassuring person, willing to advocate for their patient. And they often feel like they're spending all of their time charting and that's incredibly frustrating and that you're checking off boxes instead of providing care… And they actually get to a really busy floor where they've got six patients and they don't have those conversations and I think it leaves them feeling kind of empty.

These unrealistic expectations are also due in part to nurses on television shows, as some participants note that many shows do not give an accurate depiction of what nursing work is like. Carrie says

> Maybe they see the nurse on TV and think that's what nursing is and it's not. Maybe they're like 'Ooh, I'm going to go into nursing and make this six figure salary' and you don't. Maybe they think 'Oh, I'm going to go in and do all these doctor's orders and then go home.' And it's not that either.

Additionally, she and other older nurses believe that new nurses' unrealistic expectations are in part a generational issue. Carrie, who is 50 years old, says that the millennial generation has "had a lot stuff more handed and readily available and as a nurse you have to kind of think on your feet and something I don't think that generation is able to do that initially." Patty, who is 51, adds

> I wonder if [new nurses leaving the profession] has more to do with people that just feel like they are victims of whatever's going on in their world versus being more advocates for their life and I wonder if that is more generational. I'm just curious. You work and you don't have a perfect job. You keep it because the grass is not always greener, but it feels like the younger generation might have more of a view of, 'I'm not happy, there's got to be a better fit somewhere else'… I just really think that there's different personalities based on the age of people and I look at the nurses that are so much older than me and I feel like they put up with a lot more quote-unquote 'crap' than other people. And I just think that that's kind of an interesting perspective looking at the different ages and maybe they have different views of their career based on their age.

Although some nurses have this view, some recall they had unrealistic or uninformed expectations when they first came to nursing as well, as Vanessa had noted above. For any age of nurse, having unmet expectations could be stressful because people form identities based upon their expectations of roles (MacNeil, 1997), so a stark difference between what a new nurse anticipate and what actually happens once they enter nursing can threaten their whole identity.

Stress and burnout

A third common theme to which nurses refer when talking about shortage and turnover is stress and burnout. Stress and burnout are commonly identified in nursing as playing a large role in contributing to turnover (e.g., Apker, Propp, & Ford, 2009; Halperin & Mashiach-Eizenberg, 2014). One reason nurses note being stressed out at work is because of shortage itself. Carrie, a pediatric nurse, notes that she does not want to work on another unit in her hospital which has a high turnover rate because they are always short staffed and "people aren't as helpful because they're drowning just as much as you are, so they're not gonna step up to try to help you when they still have stuff to do too." In this case, shortage breeds shortage because nurses state that being short-staffed when caring for patients is extremely stressful.

Another reason for stress in nursing, specifically bedside nursing, is related to safety. Nurse Sharla believes that nurses are not necessarily leaving the profession altogether as much as they are leaving bedside nursing because of safety concerns which are also related to shortage:

> you're always short staffed so you're instead of having four patients you're having six patients…it's not safe and so the nurses at the bedside are getting tired of practicing in unsafe situations or having patient loads that are not safe… So you know, they're going back to school to get their master's to become nurse practitioners or they're going to a school setting or they're going to a clinic setting where the work is not as demanding and

> you know, their licenses are less at risk. If I can say that, you know, there's less room for error because you know, when you take six patients that's not really safe, so you're prone to make an error, you're more likely to make an error.

Similarly, family nurse practitioner Sandra lists several reasons for stress which include shortage and safety:

> This profession is really a blessing and a challenge, and I think there are extremely high rates of burnout for several reasons. Whether it's that there's less perceived value, you know, nurses aren't feeling valued in their specific organization that they're working at. Usually it's because of a larger issue of staffing needs and it's hard to say like, correlation, causation, etc. which is causing which, but I think a lot of it is nurses or they get tired of the physical demands, the time demands, you know, as far as over time having to juggle more tasks than they feel they're able to and then not really feeling that they're valued. So most recently there's been a lot about workplace violence, and how to combat that with, you know, nurses being assaulted and that's not only nurses or other health care professionals… I think overall it has to do with having to do more and maybe not feeling that it's safe for the patient, for the nurse. Then you get into the whole ethical dilemma of when your job is placing you and other's lives at more risk. It's unjustified to continue doing that role.

Amongst other concerns, safety is one that seems especially relevant to nurses when they think of why their profession is one of the most stressful. Nurses highlight safety concerns both to themselves in terms of being overworked and also caring for dangerous patients, as well as patient safety being put at risk due to being cared for by nurses who are overworked and therefore more prone to making mistakes. Indeed, staffing shortage impacts components of

burnout such as emotional exhaustion, which affect safety outcomes for patients (Laschinger & Leiter, 2006).

Lastly, nurses also identified lack of support when they are facing burnout, which contributes to turnover. Nurse Andrea, now a nursing professor who left bedside work, explains

> I think part of it too is there's not a lot of good mechanisms in place in hospitals and practice settings to help that resiliency to help the nurses deal with what they're dealing with on a day to day basis because I mean, they receive abuse from patients, abuse from [patients'] family members. I mean verbal and physical abuse. I mean it's really hard… And it's very emotional. Like when you lose your first patients, whether it's your fault or not, you really feel bad about it. And if you don't have the support system and the mechanisms in place to help you deal with that, nurses just getting burned out because they just get taken advantage of. Like they care and they care and they care and then they don't take care of themselves and so we've really tried to incorporate that, that sense of resiliency, that sense of, you know, you need to have that support system, you need to have whoever you can talk to, to help you think through what happens to be able to take care of yourself so you don't get that burn out... And I think that's a big reason why nurses leave. It's because they just day to day to day, just can't handle it anymore.

Social support, both from coworkers and leaders, has been found to be critical in preventing burnout among nurses (e.g., Kalliath & Beck, 2001; Ptacek & Apker, 2019). Nurse Heidi also notes that among reasons for nurse shortage and turnover—which include the baby boomer generation retiring, burnout due to high patient ratios, tediousness of certain rules and policies, and unreasonable workload—there is a lack of support for nurses who experience second victim syndrome. Second victim syndrome can happen in an adverse event when a patient is harmed or

dies and nurses or health care providers associated with the event experience emotional trauma because of it (Clancy, 2012). Heidi explains that on top of already feeling stress and burnout associated with second victim syndrome or even the constant worry that they are not doing a good job or providing the best care for a patient, they are not supported or given the resources they need to overcome the stress.

Memorable Career Moments

When talking about their jobs, nurses often share stories about memorable moments that they have experienced in their careers. Sometimes these moments become turning points which influence their future trajectory in terms of a job change, inciting an area of interest, or changing their mindset and how they approach their work. Many of the stories nurse participants told fell into four main categories, consisting of a patient dying, a meaningful patient interaction, their own realization of competency after working for a period of time, and a unique experience with coworkers.

The death of a patient

When asked about a memorable or defining moment in their career, nurses often talked about the first patient death they experienced or the death of a patient who really touched their heart. For example, Heather recalls becoming close with a cancer patient, who had a long recovery at the clinic in which she worked at the time, and his family. He wanted to spend his limited remaining days at home so they arranged hospice, and the day after he went home he passed away. Later that day when Heather walked into the office, she found a dozen red roses that were sent to her because the patient had requested his family send them as a thank you for all of her care while he was in the clinic. She said that is a moment she will never forget.

Similarly, Vanessa remembers a Crohn's disease patient who she had become attached to as they spent so much time together. The patient inspired her because despite being in so much pain she was always cheerful and even managed to get up every morning and put on her makeup and brush her hair. After the patient passed from an infection, Vanessa explains, "part of my thing with dealing with death is cleaning up the body and get them ready for the family viewing because that's my time to cry," which she did privately to mourn for the patient. Later on, the patient's husband ran into Vanessa in public and gave her a ring that the patient wanted her to have "as a friend." Nurse Samantha recalls her first patient death and how it reminded her to be mindful in how she communicates with patients' family members:

> So when I was in the hospital and when my first patient died, I mean he was very ill because he was on a monitored heart unit and I saw his wife and I had taken care of him a couple days in a row and like, compared to like two or three days ago, he was doing better. And so I remember talking to his wife and I said, 'You know, he had a good day. He's doing better, things are looking good.' And he died that night on my shift. And so that was very, very, very hard because then I had to call her back and he had young kids and it was just like, ugh. So that helped me realize the importance of being very mindful with what words you use because she was probably very unprepared for that. And I felt responsible for that.

As a nursing professor now, Samantha uses that experience as a "teaching moment" for her students so that they do not make the same mistake.

The deaths mentioned above served as reminders of past patients and people that the nurses will never forget, which brought along lessons which they apply in their careers. Some patient deaths, though, are more traumatic for nurses and completely change their mindset

altogether. These experiences often come in the form of infant deaths. For example, Jamie says the reason she burned out after six years of working in an ER was because of the death of a newborn. This experience made her decide to leave her hospital and move out of state to pursue a different nursing position. Another example comes from Erica, who describes the moment that she almost quit her job as an OB nurse:

> We had a woman that came in and had a perfect baby and she refused to have a c-section because she had had a bad experience with a c-section, like a year prior. So she refused to c-section and her baby ended up dying. They had gotten ethics involved, and so we basically saw her have a perfect baby, and then it died right before our eyes and then they extract the baby. But anyway, it was very traumatic for all of the nurses and especially me at the time. This is just a personal thing. I was in OB… for 14 years. During that time I had all three of my children, but I also had four miscarriages, so it was a very emotionally trying time for me… So seeing that one, that was my turning point and it's completely emotionally fried me. And so I should've like switched my career at that time.

Moments, especially those which hit close to home, are often impactful for the nurses caring for the patient and remain pinpoints in their career trajectories.

Meaningful patient interactions

As exemplified in some of the stories above, sometimes nurses meet patients who they form a strong connection with and it leaves a lasting impression. Sometimes patients teach nurses important lessons about life, humankind, and caring for others. Nurse Kim shares a story about when she was a new nurse caring for a cancer patient in her 70's. Kim would sit and talk with her in the early mornings and recalls the patient saying, "I know people think I'm old but I still have so much that I want to do." Kim says that

> It impacted me so much that I no longer viewed older people the same way I did before. Just that simple interchange of her saying that made me stop and think with putting my own views on life and what life means.

Kim still remembers this interchange from forty years ago because it was so meaningful to her. Other nurses recall conversations with patients that changed their whole career trajectories. For example, Monica talks about a young patient who visited her when she worked at a university clinic, seeking treatment for cardiovascular disease. When Monica could not figure out why this young, healthy woman would seek such treatment, the patient said

> My women's studies professor told us that if you have a history of sexual assault, you have a higher risk of dying of a heart attack. And I don't think that one bad date should mean I have to die young.

In thinking of what the patient had said to her, Monica thought

> I had never heard of this association, I just hadn't, and it piqued my interest and started reading about it and she was right, her professor was right. It does increase your risk and when I think about how sexual assault is being used as a weapon of war worldwide and I think about domestic violence and I think about campus rape and date rape and how many women are being sexually assaulted, and I think about how the leading cause of death in women is cardiovascular disease, it just really started making me angry and trying to figure out what can I do about it. So that's why I got my PhD. So that was a big turning point.

That one seemingly small moment completely directed Monica's mission in her career because it had impacted her so deeply. Further, some moments have influenced how nurse participants communicate with patients from that point forward. Dave recalls a time when he was completing

his public health rotation as a nursing student over 20 years ago, and he visited a patient who was diabetic, hypertensive, and had COPD. He says,

> I came up with this great game plan of things that she could do to make her quality of life better and she agreed to do them. I came back in a couple of weeks… Now I'm a checklist type of guy usually, and we started going through this list and she kept on saying no to everything. I'm like, 'Why didn't you do any of this? We agreed on this.' And she looked at me and said, 'Do you really care or are you just another white guy telling me what to do?' And I never ever thought about my approach… I had friends, close friends of all different races, creeds, colors, whatever, and thought I was a pretty savvy guy when it came to diversity and that set me back and it's a question that has carried with me all these times and I've since been around the world taking care of people and still have that in the back of my mind, to always try and connect with my patients before I try and teach them anything.

Several nurses shared stories like this that happened early in their careers that shaped the way in which they interact and think about patients.

In addition to moments in which nurses meet patients who change their lives, there are also impactful moments when nurses learn that they have changed a patient's life. One such moment occurred for Stephanie when a transplant patient she had on her very first day of work had checked out of the hospital and wrote her a letter. She says, "it's something that I look at pretty often since then, just because it kind of reminds me of the reason that I do this." Chloe recalls a day at work when she met a young man who had been volunteering at her hospital. She shares the details of the interaction:

> And he kept staring at me and I was like, this is weird, this is just weird. And finally he came up to me one time and he was like, 'You don't remember me, do you?' And I said, 'No, I don't know.' And he's like, 'I was one of your former patients.' And I kind of looked at him and he was like, 'You probably don't remember me, but I was in a car accident' and he was like a 16 year old kid and he had a head injury and he kept asking all these questions. Every time I'd walk into his room he'd say, 'Where am I at? What's your name?'… And it was hours long of me coming in and saying the exact same thing to him. I'm trying to calm him down. And his mom was with him and just reassuring and he said, 'You know, I don't remember much, but I remember your voice. I remember you. My mom tells how caring you were, and patient with me.' And he's like, 'I came back to volunteer in this ER because you guys did so much for me and I'm going to medical school because of this… You influenced my life, you know, and you don't even remember it and I appreciate it.' And I thought, oh my gosh, this is one I will dream of. You know, like you've made a difference. And you don't hear those stories very often, so I tell that story all the time because it's the little things that you don't remember doing for a patient. And I don't remember him. I don't remember doing anything, you know, it was just, to me it was a routine day, normal day, but to him it made a big influence and changed his career trajectory. So pretty cool.

Chloe would never have known about how much she had influenced this young man's life if she had not seen him that day, but it was a reminder to her that the care she gives to patients in a typical day can be memorable and life changing for them. Another memorable moment that impacted a little girl's life as well as the nurse's happened to nurse Sharla. She shares

So two years ago I was working at our clinic on the west side and [the patient] I had at the time, she was four. She was four years old and I'm a black woman… And she was white… and her pediatrician is a male, white male. So I walked into the room and she looked at me and then she lays on the table, folds her hands on top of each other and puts her face into her hands and so her belly's on the table and she's kicking her feet and she's throwing a tantrum basically. And I walked in and I was like, 'What's the matter?' Like I typically would do if someone's upset. And she lifted at her head up and she looked at her mom and she pointed to me and she said, 'I don't want her.' And I said, 'You don't want me?' And I was like, 'Do you want me to leave?' Not really knowing. Like I thought she was having a bad day… And she said yes, and I was like, 'If I leave then who's going to take care of you?' And she said, Dr. [name], like her pediatrician and her mom seems to get like way more upset about this than I thought she—than seemed normal and so her mom said 'Stop it.' And she said, 'Why don't you want [Sharla] to take care of you?' And she rubbed her skin and she said, 'Because this,' and she rubbed her skin. So you know what that means. So now I'm like, oh my gosh, and my heart, like literally dropped to my stomach. Now I'm a black woman. I've had situations before but never with like a four year old child because let's be honest, the four year old child doesn't learn that from watching Mickey Mouse Clubhouse… So in my head now I'm like, okay, I have like two seconds to react. And I always wear my nails, like really colorful and sparkly because it's a great distraction for my patients when I listen to them. So I said to her, 'Well, I'm sorry, you know Dr. [name], he can't help you but I can and I know that you're here to see me because you know, you're sick and I want to do all that. I can make you better.' And her mom is like, 'You better stop, get yourself together.' Like she's yelling at her daughter, so

then her daughter cooperates a little bit. And I started listening to her and I'm looking her in the eye like I am trying to—I am not letting her lose eye contact with me. And I said, 'Wow, your heart and your lungs sound so good and so strong.' And then I smiled at her like a huge smile and I'm like really close to her face and then she smiled back at me and I was like, yes, I got her, I got her now. Like we're gonna get through this, we're going to get through this. And then she started rubbing my hand and I said, 'See it doesn't rub off and it feels just like yours.' And she looked at me and started shaking her head and then she moved her hands down to my fingernails and I had like pink fingernails with silver sparkle and she was rubbing my finger nails and I said, 'Do you love my princess fingernails?' And she said yeah. And she said, 'And I love my princess doctor.' And I was like ha! And I was like 'You know what, I love my princess patient.' And then she stood up on that table and she gave me a hug and I looked over at her mom and her mom like, she started to walk over towards us almost to like break it up because she didn't know how I was going to react, you could tell. And so I like, I shooed her away and I shook my head and I put my hand out and I was like, no, no. And I said, 'I think both of us needed this today.' And then she sat back down on the table and she gave me a kiss on my cheek… I seen her subsequent times, but a year later… she was in this like community play, a theater group… And her mom told me about it and I surprised her and I went so I took a picture. So it's like we've come full circle. So now whenever she is coming to the doctor, she only wants to see me and she named a doll after me. And so what started as like an awful like, you know, this girl didn't want to see me because I was black turned into now I'm the only person in our office that she wants to see. And that just, yeah that will stay with me forever. So that's why I'm a nurse. That right there. Little

> by little we change the world. So she changed my heart and I feel confident in saying that like I changed her heart and hopefully maybe changed her mom's heart a little bit.

This defining moment in Sharla's career gave her an opportunity to overcome an adverse situation and build an unexpected relationship that not only impacted her life but the lives of her patient and the patient's family. These moments described above and others were identified by nurses as meaningful moments involving patients that help to define the nurses' careers.

Realization of competency

A third way in which nurses talked about memorable moments in their careers is by describing the times early on when they realized their competency as a nurse. Commonly new nurses enter the workforce feeling unconfident and worried that they may not be able to handle the pressures of caring for people's lives. However, many of them have small moments, whether it be in their own realization or receiving a comment from a patient or coworker, when they suddenly feel that they have "made it." For Brooke, it was after working as a nurse for about eight months. These months were filled with struggle and then she had what she considered her worst shift ever where she cried on her nurse mentor's shoulder. She says

> And I got through that night and it was fine. And I had problems and I fixed them and so yeah, I think, that's what makes like the struggle of being a new nurse worthwhile when you do finally get to that moment, you like realize. I think that was a big turning point of just like, you know, whatever happens, it's still only 12 hours and you still get to leave at the end of the day and it's going to be okay… I hope that new nurses all have that moment. But yeah, I think it feels good when you do you realize it's going to be okay.

Similarly, Vanessa recalls early on, on a day on her mental health rotation when she locked herself in a room, paralyzed with fear and crying that she would not be able to handle the job.

But then she witnessed a seasoned nurse talking about a patient's treatment and Vanessa asked how she knew that and the nurse said she learned it over time. Vanessa recalls thinking, "I'm never going to be that smart." Until one day, she walked in and realized that she was a seasoned nurse and it occurred to her that she did it.

Additionally, sometimes it takes a coworker or a patient to help a nurse realize that they have "made it" as a nurse. For Dave, it was the moment when one of his clinical instructors said to him, "I would let you take care of one of my family members." To Dave, that is the highest compliment that can be given to a health care provider. For Sandra, it was when a patient of three years said to her "You treat us as people not as numbers, you really listen, you take the time to get to know us and not only do you take care of us, but you treat us like family." Sandra says that will always stay in her mind because that is exactly how she wants to make people feel.

Unique experiences with coworkers

Nurse participants also recalled experiences, often dramatic and unpleasant, that will always remain a defining story in their career. One of these unpleasant experiences happened to Ashley in her third year as a nurse when there was a 42-year old brain cancer patient with a "do not resuscitate" order, whose primary nurse was much more seasoned than she was. She retells the emotional event:

> [The seasoned nurse is] going to take a break and all times that's when he's going to code. I go running back there and the [patient's] wife grabs me and the kids are in the room and start screaming, 'Do something, do something. I've changed my mind [on the DNR order].' Okay. He's the one that of sound mind said 'I'm done. I'm not, I'm signing. Do not try to—Don't put me on a ventilator, for what? Let me go.' And in that moment of only having not even three years under my belt and to have a person in my face

> screaming, ‘do something,’ and your gut says I need to do something, and then to be that patient's advocate. Then the seasoned nurse comes running in and goes to grab the paddles and we're going to do a code and I'm going, ‘no, no.’ I'm trying to be calm. I mean there's, you know, I just thought what a nightmare. And I kept going, ‘Look at me. He does not want—’ you know, I'm thinking—Come on. It's still gives me chills because I remember thinking, how did I ever stay calm, that I have no idea, but I remember that turning point of that person in that bed can no longer advocate for themselves and is up to you against all odds. You are that advocate and that will forever stick with me.

Samantha had a similar experience, in which she had to remind another nurse and a doctor who started coding a patient that she was a DNR. She now uses that as a learning experience to tell others how important it is to know the code status of patients but also if there is anything else unusual about them that is important to know. In these experiences, the nurse had to stand up to someone with more power than them, but they knew they had to do it as an advocate for the patient. Monica also had an experience like this, when a surgeon touched one of the drips on a patient which Monica did not believe was safe to change, so she called security on the surgeon and he was suspended for two weeks. She recalls, “That’s a scary thing to do because there are these power differentials…That was a turning point though, when you realize that you have more power than you might think.” In these situations, newer nurses especially may feel hesitant to stand up against what more seasoned or “powerful” coworkers are doing, but many of the nurse participants said that it is important to do what is right as their duty to the patient. These experiences served as defining moments because they were glad that they followed their instincts.

Met and Unmet Expectations of Nursing

In individual interviews, nurses were asked to talk about what their expectations were going into nursing and how those expectations played out once they became a nurse. It is important to understand the differences between expectations of nursing and reality once becoming a nurse because a conflict between expectations and reality could result in re-conceptualizing one's occupational role (Corwin, 1961) and threaten one's identity (MacNeil, 1997). Further, findings mentioned earlier in this study suggest that unrealistic expectations are one reason for the high rate of turnover in nursing. Five major themes emerged when nurses described their early expectations of the job, which include reasonable expectations that did not differ from reality, the expectation that patients and coworkers will love them as a nurse, handling insurance issues as part of their job, that nursing would not be as busy and demanding as it actually is, and also pleasant parts of nursing that were not expected.

"It was pretty much what I expected"

Although most nurses identified expectations that were not met once they became a nurse, some participants were well prepared. These nurses often knew someone, such as a family member or close friend, who was a nurse and from speaking with and even shadowing these people on the job, they said they had a fairly accurate perception of what nursing would be like. For example, Morgan says, "I feel like I had a pretty good idea of what I was getting myself into." She was warned ahead of time that the job would be exhausting and challenging, and even though she recounts days in which were that exactly, she says, "I don't feel like it completely knocks me off." These 'reasonable' expectations of nursing—whether it be the difficulties of the job, what a typical day will be, or even some of the extreme situations that many nurses encounter at some point—have made it easier for some nurses who were well informed before

entering the profession. However, many new nurses do not have this experience and have confronted a number of surprises, some of which are described next.

"Everyone will love me"

One misconception that nurses indicate having once entering the workforce is that patients and coworkers alike will be welcoming and grateful for their work. Nurse Andrea describes the reality shock that comes from what nursing students think compared to reality:

> You will always have that little halo effect. Like 'Oh I'll be taking care of people, and it will be wonderful, and everybody will be happy, and they'll love my care' and all that. And you think as you're going through school, it's always gonna be that ideal situation. And then you get out into practice and you're like, well, you know, your patients are not always so happy to see you. They're not always nice. You're getting yelled at by the physicians, you know that you are overwhelmed because you have so much to do and not enough help. So it really is a reality shock when you get into that because you don't realize all those aspects of nursing when you're in school or when you're thinking about nursing. I think people have seen nurses on TV and they're like, 'Oh, beautiful.' And they don't look stressed out, time to chat and gossip. And real nurses are like, 'I don't even have time to pee today.'

Similarly, Dawn recalls how different her expectations were when she started her career in a children's hospital:

> I just envisioned that everyone would love me, like patients and their families, and it would all go perfect and I would, you know, everyone was the best person out there, you know? And then I was working at [hospital] so I got kind of jaded I think the first couple of years because I saw a lot of, you know, there's just a lot of child abuse and seeing that

> happen, I wasn't prepared for that. And then of course everyone did not like me, like my God, getting yelled at by people or, you know, especially being a new grad, like 'do you know what you're doing?', that sort of thing. So that was hard the first few years.

Many nurses recall this feeling of not expecting patients and patient families to be so difficult or rude to them. Additionally, many of them expected coworkers to always be pleasant and work closely together, but unfortunately, as mentioned previously, all of them had experienced incivility and nurses "eating their young" at least at some point early on in their career.

"I didn't know I'd be handling insurance"

Another issue that some participants mentioned not expecting was having to work with insurance. In fact, Sandra said she felt well-prepared to be a nurse but one thing she did not expect was "some sticky things that go into giving care, like insurance coverage and whether you're talking about the Medicaid/Medicare versus private insurer." She adds, "People didn't really tell me about the things that aren't quite care-related but have significant impact on care that maybe would have helped to deal with situations a little bit better." Although not all nurses have had to handle insurance issues, several participants have been in jobs in which the responsibility fell to them, whether it was supposed to or not. Jamie explains early in her career, around 25 years ago, in the state she lived at the time,

> The whole Medicaid system was being so overwhelmed that the state couldn't handle all the cases that were new cases being signed up. So what they did was they outsourced the Medicaid program to Humana and there was one other one. Well, they're an HMO. So in order for a Medicaid patient that had Humana to go to the emergency room, they had to be preapproved. So it fell back on nursing or the physician calling, naturally. They wanted to hear from who would describe the medical reason why they needed to be here.

> The nurse had to call before the patient could be seen and this backed up the ER, this backed up the nursing. It was just horrible. So you had to call on each patient you had when it actually was supposed to be the medical professional calling, not the nurse. So that's what I didn't see. I didn't see that I would be assuming some of their responsibilities as physicians.

She mentions that there are still issues like these going on today so this is still a very real possibility for nurses to experience, which may be one aspect of the job that they are not expecting.

"I never imagined it could be this busy and demanding"

A very common theme in what nurses described as something they were not expecting is that their job would be more busy, demanding, and overall difficult than they anticipated. For example, Monica says, "I still carry peanut butter because I'm used to eating a scoop of peanut butter to get you through a 12 hour shift." Even Samantha, who worked many hours with an established nurse in the hospital for her capstone in school and said she already knew "this is going to be harder than I realized" was hit intensely. She says,

> Even that experience did not prepare me for what it was like to be on the floor, taking care of your own patients for the first time. Like that was a shock I felt and I graduated number one in my university. Like I was smart and prepared and then I was on the floor and I was like, what the hell has happened? Like this is nuts because it's like a war zone.

Despite being an excellent student and feeling super prepared, the stark difference of working on her own and adjusting to this new environment left her feeling "underprepared and overwhelmed." Nurse Sharla also describes some of the various components that go along with the busyness:

> When you do clinicals as the student, like you get a glimpse of it for like six hours or something like that, but then you go and work a 12 hour shift and you know, like you can't move the next day or like you're so exhausted. So I didn't expect it to be as hard and as challenging and as emotional, as emotionally draining. And that's kind of talking about both when I was a bedside nurse and as a nurse practitioner, you know, I knew it wasn't going to be like a cakewalk, but I didn't know that most days like 90 percent of your day were going to be really hard and 10 of them were gonna be like medium hard. So I guess I didn't expect the level of intensity and the level of, kind of how grueling it is, even though it's not necessarily a physical job, it is a physical job, if that makes sense. Very demanding of energy and demanding on your body and very taxing on your body. And from that both emotionally and physically.

Even if new nurses are told that the job will be exhausting, emotionally draining, and grueling, it is still hard to imagine until they actually experience it themselves. Nurse Erica makes this point:

> I think every day on the floor is so different that I think any day is just different than what you would ever expect. And I think at the same time more intense and more real because you develop relationships with, of course nurses, but like the family and then you have experiences that you never thought you would have… So you can't learn any of that in school or know that it's coming.

As the above example illustrates, becoming attached to other nurses as well as patients and their families adds another dimension that amplifies these already strong feelings. However, not all of the shocks of getting on the job are difficult. Some nurses experienced positive aspects of the job that they did not anticipate, which are described next.

"There are also pleasant surprises"

Although many of the unmet expectations or surprises of entering the nursing workforce are unpleasant, there are also some good ones. As mentioned earlier, nurses often describe their jobs as rewarding, but some of these rewards are unexpected. For example, Carlos says "I expected it to be rewarding in one way and found it rewarding in a different way." He goes on to explain

> So when I first entered into nursing school was I [thought]…'I'm going to go cure the world and fix all of its ills,' and expected to do that through the ER, saving one life at a time or what have you. I guess I was chasing this adrenaline high and expecting that to be, here's this reward of 'whew we made it through this chaotic situation and look at what happened.' But I found it more rewarding of the relationships formed and knowing like I helped this person… I found I got just as much satisfaction of like how this person—Cause I sat and talked with them… not just me but my team that I'm working with, doctor and the CNA, [the patient is] gonna get a few more years. Diabetes isn't going to be the end of them right here, right now. They're going to go see their granddaughter, do this thing that's pretty sweet. It's kind of Ninja. And so I found I just really enjoyed those, I don't know, public health measures, population health measures as much as those were just as rewarding.

In this example, Carlos not only found it rewarding to save people's lives as he expected but knowing that the individual person was going to get to live more life in part because of his work. Another common surprise for nurses is finding that they actually enjoy working in a unit that they did not expect to enjoy. Several nurses mentioned trying to avoid certain units when they first began working in the hospital only to end up working there because of either a school

rotation, a desperate situation requiring them to take the job, or another reason. In some cases, they discovered that it was an excellent fit for them. Others talked about working in units that never even hit their radar. Nurse Amelia describes her unexpected situation working in a pediatric progressive care unit:

> I actually applied to a different unit as a student nurse. I applied to work in the PICU [pediatric intensive care unit] and they had already hired someone so I had an impromptu interview with my current manager… And I was like, well I have no idea what this unit does. So whatever. But then once I started working there, I loved it. I always expected that I would want to be in an ICU setting and do, you know, super critical care. And I didn't think I would like anything else. But then when I started working on my unit, I didn't expect it to be so much fun. Like, yes, when the kids are really sick, they barely get out of bed. But when they're feeling okay, like we play games together, we go to the playroom… So I just didn't expect that I could work in a place where kids were critically ill and I would be challenged in my critical thinking, but also be able to have fun and play as well.

Even though many nurses describe the unexpected busyness of their work, some are pleasantly surprised by the enjoyable aspects that they did not anticipate, such as Amelia's experience above with spending time with her young patients.

Career Decisions

Both scholars and nurse educators alike are interested in understanding why individuals choose nursing as a career option (Kersten et al., 1991). Research has indicated some reasons for choosing the nursing profession include having a loved one in the hospital, knowing someone who is a nurse, and a personal interest in health care (Larsen et al., 2003; Wu et al., 2015). Some

of these decisions are described below in the current findings; however, it is also important to consider decisions to change jobs once someone is already a nurse. Below, I highlight not only some initials reasons which drove nurses to choose their career in the first place, but also some turning points within their careers which influenced them to leave their organization or unit and pursue another path within nursing.

Decisions to become a nurse

As indicated above, there are a number of reasons why people choose to become a nurse. Interview participants identified several various reasons, but three major themes which emerged include influence from family members and/or friends, a triggering childhood event such as a personal illness or an illness of a family member, and reasons which led them to feel that nursing was the most rational career choice for them. These are described next.

Influence from family and friends

Many nurse participants knew one or several people who were nurses or in health care which influenced them to become a nurse. Although some of these influential people actually told the individual to not pursue nursing—like Dave's mother, a nurse, who tried to discourage him from being a nurse initially because of some of the stressors involved—many of them either outwardly encouraged entering the profession or served as an inspiration to become a nurse. For example, Monica's grandmother and mother were both nurses, but it was her father who first brought up the idea to her of going into nursing when she was considering career options. Additionally, Monica had several friends who were nurses who gave her advice. Similarly, Sandra identifies her mother being a nurse as the reason why she chose the profession herself. She recalls going to work with her when she was younger and also being given volunteering

opportunities at the hospital because of her mother. She says, "A lot of it was seeing what my mom did and the nurses that she worked with. I've volunteered in the hospital when I was in high school and I just really liked the care that nurses provided." Dawn also recalls that in addition to her grandmother and mother being nurses, going to work with her father, who is a physician, gave her the opportunity to see nurses in action. Although her father "pretty much begged" her to go to medical school, she was interested in nurse bedside care. Other nurse participants' parents were a little more forceful, such as Natasha's mother, who said Natasha could go to college with her boyfriend if she became a nurse. Natasha recalls,

> I always wanted to be something in the medical field. But I really had no idea what and I was adamant that I wasn't going to be a nurse and so then I met a guy in high school and we started dating and he was going to go off to college and I wanted to go with him and my mom saying, 'Well you can go, but you have to be a nurse.' I was like, fine… I think it was a really silly reason why she made me be a nurse but I do get it and I think she probably saw something in me that I didn't see in myself at the time and therefore that's why I've been successful as a nurse.

Fortunately, the obligation to her mother to become a nurse worked out well for Natasha. For other nurses, they just needed a little push from friends to continue pursuing nursing. For example, Vanessa had already earned her master's degree in nursing education but says,

> I had no desire to go get my PhD. But I had a couple of friends who said, 'Oh, come on, it'll be fun' they said. So we all three ended up going and getting the PhD in nursing education and… the only regret I have is that I waited.

Even though Vanessa had already been inspired to become a nurse from her grandmother, who was an LPN, the influence from her nurse friends pushed her to pursue an additional degree to further her nursing career.

Triggering childhood events

Another common influence which nurses said led them to choose nursing is some event from when they were younger, such as having to go to the hospital themselves or seeing a loved one in the hospital. Nurse Carmen experienced both of these situations. Being born with a congenital heart defect, she experienced firsthand the kind of care which nurses provide, and says, “That really changed I guess the way that I viewed what my role might be like as a nurse when I made the decision to go into medicine.” Additionally, when her mom got cancer and until she passed away when Carmen was in college, Carmen witnessed the impact that high quality of care from nurses had on her entire family. She adds,

> I think really just because of all the experiences that I had growing up and then my mom's experience as a patient herself and everything. I just saw how much of an impact nurses had on our care, like as a family when my mom was dying and I really wanted to have that kind of impact, you know, in the life of another person and I just have felt like that in a way has almost been like a calling, you know, to me, like a very humbling calling.

Similarly, Pam had seen her grandparents receive care and also remembers some personal stays in the hospital when she witnessed nurses, good and bad, at work:

> All of my grandparents had passed within a year and a half when I was in middle school. So some of them lived with us at home, so seeing, you know, like a hospital bed set up in my dining room and just always having that some sort of medical something going on with all of them pretty much throughout my life, like while they were alive, always

> played a huge part and there were some nurses that were super amazing. I was like, 'Oh my gosh, she was so nice. She was nice to grandma, like she did this, that and the other.' And then there were other nurses that you're like, 'Why did you go into this? Like if you hate people, like why are you doing this?' And then so in addition to that, when I got into high school… I had kidney stones, appendicitis, but dealing with like being a teenager in a hospital setting, you know, as a female it was just because you want to like protect your privacy, you don't want to just put it all out there, you know all that stuff. And I had some nurses throughout a couple of different hospitalizations that were amazing, and I had one… I still remember her name when I was 14 and she was atrocious. She was awful, like, I mean, so we all know what a urinary catheter is. She did that without telling me what she was doing. Like 14 year old girl had no idea what was going on… And that was one of my things like throughout nursing school and throughout, I mean especially that first year as a nurse out on my own, but I never wanted kids to go through stuff as minor or major.

Not only did the good nurses make an impression on Pam, but she distinctly remembers her experience with the "atrocious" nurse, which influenced her and the type of nurse that she is today. She says that the top three most influential experiences that led her to become a nurse include her grandfather being in a nursing home, her own hospital visits, and shadowing nurses in a PICU. Tiffany also recalls how highly her grandfather spoke of his nurses when he was being treated for leukemia. She states, "My grandpa was a man of few words, so when he would speak about someone with respect and admiration like he did with his nurses, it was very powerful and meaningful to me." She recalls, "His passion for how awesome his nurses were and then caring for him, led me to want to be that for someone else." Similarly, Amelia was inspired

to provide the type of care her cousin did as a nurse when their grandmother got cancer. She explains,

> I was already thinking about being a nurse, but my junior year in high school my grandma got really sick with colon cancer and my cousin had just become a nurse and she moved in with my grandma and took care of her until she passed and just kind of seeing their relationship as, you know, grandma and granddaughter, their bond together grew, but just like seeing how she treated my grandma and how gentle she was and caring and was trying to like fulfill her needs, physically, but also emotionally as well. I was like, wow, you know, I think I really do want to do that cause I mean doctors can be great, but I feel like there's just something really special about the nursing profession in that caring aspect. And maybe it's just because it's, you know, a bedside nurse is there all the time, but that was the deciding factor for me.

So even though Amelia was already considering becoming a nurse, seeing the ways in which her cousin cared for her grandmother was the tipping point. In several instances, nurse participants retold experiences of watching a nurse provide care and realizing at that moment that nursing was definitely the best career choice for them because they wanted to emulate that care that they witnessed, or in some case, treat patients better than they had seen their loved ones or themselves treated.

Rational choices

A third common reason that nurses say they were led to become nurses is because they felt it was a practical and rational choice. When deciding on a career, it can be important to consider the pros and cons of different professions and decide which fits your needs the best. That is what these nurses have done, for a variety of reasons. For Morgan, her mother who is a

physician recommended nursing to her because schooling was less expensive than medical school and it allowed her to advance throughout her career and manage a work-life balance. Carlos also weighed the benefits of nursing compared to other careers. He shared some of his thought processes at that time:

> I thought, okay, what's my next step? What should I actually be doing? And I realized, okay, what do I want to do? What am I good at? I'm good at science and I liked and I want to help people with science. And I just listed all the professionals that did that. And engineering obviously not going to be me and I don't really want to be put in a position where I would have to, I mean I didn't want to help one person at the cost of another person per se. So for example, police officers undoubtedly do provide public good, but there is a trade off with that cost benefit and I feel that a nurse doesn't necessarily have that or math or medicine in general, when you try and help and sometimes the patient dies or there's some other issue, but hopefully I didn't make it worse, unintended consequences. So that's how I just kind of drifted towards nursing, just trying to look at what all my options were and just trying to reason through what would, how that could go forward with that. And I'm also, I would describe myself as just like a peace loving hippie. So just in general, anything where I would have to harm someone is just out for me. So again, I recognize the need for military and, but I don't know that I can be a part of the military because I might have to do, you know, things that would go against the peace that go against my pacifistic nature. So yeah, I just was guided towards being a nurse.

He described his path as “gradual currents that took me in” and led him to choose nursing over other possible options. For many nurses, it is a second career. Nurse participants shared

experiences of being in professions such as social worker, veterinarian, military officer, geologist, and others but chose to change careers into nursing. For example, Patty was in psychology for 13 years but after weighing her options she found that nursing paid better, allowed for more opportunities, and is more "black and white" than psychology. For other people, they chose nursing because it allowed them to support themselves in a dire situation. For example, Rachel's life was turned upside down when her husband left her. At the time, she was working on her doctorate in public health, but was forced to switch gears in order to have a full-time job that provided the salary and schedule which allowed her to care for her children. In these experiences shared above and in others that nurses provided, sometimes nursing was the best choice simply because it made sense for their skills and needs.

Turning points in the nursing career

In addition to their initial decisions to choose nursing as a career, nurses discussed moments once they became a nurse that led them to choose a different path within nursing. With the exception of three, all nurse participants had changed organizations at one or often several different points in their careers. I sought to examine the reasons behind these changes to further understand aspects of how their personal, work team, organizational, and professional identifications interact with one another. For instance, many nurses had family needs which demonstrated how their personal identities at that time conflicted with their work identities. Other nurses experienced unfavorable work environments which compromised their work team or organizational identities. Third, some nurses received unexpected opportunities in which they perceived the benefits to be greater in pursuing the opportunity than remaining close to their work team or organization. These are described in more detail next.

Family needs

A common reason for nurses to change nursing jobs relates to family needs. This may be more prevalent in a female-dominant field such as nursing as many female nurse participants mentioned moving to a different job after having children as it allowed them a more flexible schedule. Nurse Sienna explains

> A lot of young women, everybody like goes and has babies takes a few years off, you know, kind of always looking for something. I know that a lot of my job changes were like whatever my family needed, so whatever allowed me to take care of my family and be, you know, and do a career in nursing.

In addition to children-related needs, many nurses switched jobs to move with their spouses for their work. For example, Morgan's husband had to move for his military job which led them to move across the country where she works in the NICU. Sandra, who has had to move several times with her husband early in her career, says she is grateful for the flexibility that nursing offers which has allowed her to do so. Other nurses were forced to change jobs when they were going through divorces. For example, Sienna had just had her third child and had cut back to working as a PRN, which is on a part-time, as needed basis. Her husband at the time had started a successful home health care business which she helped with, until her entire life changed. She recalls the experience:

> And then he told me he was cheating on me and that he didn't want to be married to me anymore. So, like, game changer, right. So I didn't want to keep doing the business with him that he was making money off of with his girlfriend. So I handed him the phone and I went back to the ER where I knew I could work three days a week and, you know, be

> able to support me and the kids and not have to worry about whatever it was that he was doing.

Although it was certainly not what she wanted nor expected to be doing, Sienna was forced to switch jobs in order to care for her children and get away from her estranged spouse. Several nurses shared similar stories of taking jobs in nursing which offered them the best opportunity to deal with their current family situation.

Unfavorable work environment

Another reason that nurses frequently stated leaving their units or organization and taking a different position within nursing is because they wanted to get out of an unfavorable work environment. Recall earlier Jamie's experience of burning out in her ER job because of the death of an infant. She knew she had to make a change, which led her to move out of the area and work in a cardiac cath lab. Another switch she made was while working in a stressful position as a charge nurse and realized that she was "not adding to the team. I was being that toxic nurse." She felt the situation was not the best for her and decided to leave. Other nurses leave their jobs because of difficult leaders. For example, even though Dawn loved her job and manager in a children's hospital, she could not tolerate working for her director. In this case, the stress of working under that director overpowered how strongly she connected with her organization and other coworkers. Similarly, Sophia recalls the turning points in her careers and states, "I hate saying this, but I have to say a lot of my career decisions were driven by bad leaders." Being a leader herself, she saw many ways in which others were ineffective in managing others and in most of her career changes, it was the deciding factor to leave. Another example of conflict between occupational identifications is Natasha's experience working for an organization that she loved until there was a change in management. She says, "Our management started to change

and just their philosophy of the way we were going to handle patient care and that sort of thing has changed. And so I decided it was no longer for me." Similar to Dawn's experience above, the unpleasantness of the leader was greater than the strength of their connection with their work team or organization, which led to them choosing a better alternative.

Unexpected opportunities

A third major reason why many nurses changed positions within nursing is because of opportunities that came unexpectedly. These are sometimes positions that the nurse is not aware of or even believes is qualified for, but maybe a friend or coworker tells them to apply or someone contacts them with interest. For Heather, many of her job changes were because of these positive but unanticipated opportunities. After receiving several grants which funded her research in nursing, just as it was winding down, she was contacted by the senior Vice President of a hospital who invited her to work in the position that she still has today, 13 years later. She reflects back on these and other opportunities that she has had as "out of the blue" twists and turns. Nurse Vanessa notes that each job she has gotten was because someone had told her about it. For example, she got a job as a nursing chair because someone referred her and that person and had reached out to her. Another job in occupational medicine came about because a friend told her that she would do well and then picked up the phone and made her call the manager about it. She retells a recent story about a job that she eventually applied for after it was sent to her several times:

> I got an email [about the job] and I deleted it. I got an email, the same email from somebody else and I deleted it because it was out of [state]. I'm like, I don't want to move [to that state]. And so then my boss, my current boss sent it out to all of us and I deleted it again. And then my friend… she comes to my office, she goes, 'Are you going to apply

> for that?' I'm like 'No, I don't want to move to [state].' She goes 'You can do telework' and I went, huh?... I mean, yeah, the things that happened in my life, you know, God's there for sure. The next morning I got it again. So I got it four times from four different people. Yeah. So that's basically how I've done it. I want to be the best person for a job and if I don't get a job, it's not the end of the world, but I look at the opportunity to apply and interview as an experience.

This was surely a position that Vanessa would have completely missed if it was not brought up to her again and again. Nurses speak about these serendipitous opportunities because they are often outside of what the nurse would ever even consider doing, only to be contacted by someone who feels they would be good for the position and they find out they actually really enjoy it.

As seen in the varied examples above, there have been a number of paths which led these nurses to choose their careers. Often, many of these decisions are not cut and dry; there are certain moments which can be pinpointed as the 'turning point' moment but there are often a number of factors which contribute to their decision.

"Job" versus "Career"

An interesting topic worth exploring is the conceptualization of whether nursing considered is a "job" or a "career." This stems from Clair's (1996) and others' work on organizational socialization and what is considered a "real job." Since nurses often move from unit to unit or even to different organizations, some may consider nursing a "job" with connotations of impermanence and unprofessionalism. Jamie points out that this debate of "job" versus "career" contributes to the struggle in nursing striving to identify itself in the medical community. Nurse Dawn explains why some may think of nursing as a job:

> I think nursing as a whole shot themself in the foot, why it's not considered by some, people consider it a job versus career because we have like 500 different avenues that you can take and you know we have the associate degree versus a bachelor degree, and associate degree nurses think differently than bachelor degree nurses and I think they do. I think bachelor degree nurses delve a little bit more into the critical thinking and clinical judgment and not just because to me a job is if you—and there are nurses that operate like this that it's very much task, like 'the doctor says do this, so I'm going to do this and that's going to be the end of it. The patients ask me questions or I can sense that somebody needs advocating for, I'm not going to go there, I'm just going to stop it because that's not part of my job.' Versus a career, I feel like that you don't shut yourself off to that, which is what I mean. I don't feel like I ever shut myself off from asking more questions or advocating.

Although Dawn considers her work a career instead of a job, she points out that there are many nurses who do consider it a job and do the bare minimum work because of how they conceptualize it. This also speaks to the earlier debate of whether nursing should limit its points of entry to require a minimum bachelor's degree, as nurses discussed the limitations and changes needed within the profession. Jamie defines it similarly, as she says that some people actually think nursing is "like you're a glorified waitress" and nurses who see it as a job are "looking for the next vacation" and "They just read off the discharge instructions with no investment in that patient." She says these nurses are "toxic because they don't want to be there and they don't want to be a nurse" and "eventually move onto something else that's no patient care or non-health care." However, nurses who consider their jobs a "career" will put in the extra effort and strive to make a positive difference. Sophia says "it's that line between 'I can't believe they pay

me this much to do this' and 'they don't pay me nearly enough,'" but she also points out that "fit" is an important component, because they have to find a unit or organization which makes them happy with their work.

When asked whether they felt their work was a "job" or "career," most nurse participants said they felt it was a career. Andrea, a nurse of 18 years, says

> I view it as a career. I think because it's—I don't think it defines me, but I mean I think it's a big part of who I am and in my case I mean I've always been advancing and moving forward and continuing my education. So maybe a nurse that works the floor and is not interested in advancing their, you know, they're happy doing that, which is great, maybe they just see it as a job… Like my current position, as an educator, I don't leave my job here. Like I take it with me, like I have to. It's not just a nine to five job… I'm always thinking about it. I'm doing things on weekends, I'm doing things, you know, it's not like a job on the unit were you, you know, take care of a patient for 12 hours and whatever doesn't get done can pass onto the next shift. It's like, well, if it doesn't get done I still have to do it… And to me a career is something that's kind of more global, more with you all the time. And I feel like that in my case, that's what I have.

Along with Andrea, several other nurses suggested that perhaps more nurses who work on the hospital floor may view their work more as a "job" as compared to those nurses who have moved around and found their fit, as Sophia mentioned above, such as those who are now nurse educators or administrators. In support of this point, nurse Amelia says that although she views nursing as a career, what she currently does is a job. She says, "this is my current job and maybe my job will morph into my career and I could go back to school and… merge the two together."

This suggests that she is still working to find her fit within nursing but once she does, she may feel that she has landed a career.

Advice to Future Nurses

A final theme that emerged as important within nurse communication about their job is advice current nurses would give to future nurses. This is important to explore because it can have helpful implications for practice, as students and others considering nursing as a career may not have other resources to obtain such advice. Most of the nurse participants in this study noted that they barely or did not at all ask questions when they were considering nursing as a career. In fact, the majority of participants who said they did ask questions were those who were older in age and had already had another career before nursing. This suggests that young people may seek out advice less frequently and they may not know what questions to ask. Among nurse responses, five major themes of advice emerged, which are described below.

Nursing is difficult

First, although it has already been mentioned previously when nurses described their work, it is necessary to include here that nurses feel that someone considering nursing as a career should know that it is very difficult. Natasha worries that most people think nursing is just like on a television show like Grey's Anatomy. She says

> They feel like nursing is hospital and it's taking care of really sick people who are on all these different IV drips with lots of tubes hanging out of them. That's their view of nursing and that is a view, but that's just really small view.

She adds that nursing is much more broad than this and there are multiple different degrees and types of work that nurses can do that many people do not consider. Brooke wants people to know

that nursing is difficult because there is pain that comes with the privilege and it is a large learning curve after graduation. Samantha adds that people may glamorize the work, but in reality nursing is difficult because “you’re going to be starving and you’re going to end up eating food out of the patient’s cupboard.” The realization of how challenging the work is can lead many new nurses to drop out, but Samantha gives the following advice:

> You need to give it six months because after six months I was like, ‘Oh, I got this.’ But it took six months of showing up to work every day and hating it and… after six months, if it's not working, then figure something else out. But give yourself six months. And then I tell them, you don't have to work in the hospital forever… You can do anything for six months.

Kim also stresses this commitment and that people must make sure they are going into nursing for the right reasons. She explains

> If you're just enamored by calling yourself a registered nurse… then you don't know why you're getting into it. You're going to crash and burn real fast because nursing is not easy. It's hard. It's really hard at times. It's hard to see people die. It's hard to take care of people when they're sick because many times they don't appreciate it right then, but later on they realize what you did for them, but when you're sick and you're right in the worst of things, family members who need support and trying to reassure them that everything is being done that can possibly be done for their loved ones without saying everything's gonna be alright because it may not, and then when it's not alright, knowing what to say, you got to be able to take the good with the bad… It isn't about the glamor of the job. It's the day in and day out grind sometimes and you've got to love it. You've got to be passionate about it and it really has to fulfill... There's a spirituality to nursing and I think

> to health care period, that you have to feel that sense of spirit, spirituality, that sense of giving to people, of getting back so much of this sense of connection and purpose that if you don't have that in nursing, I think you aren't going to be real happy and for those that can't, luckily there's other jobs in nursing where you don't have to make quite that connection.

These examples urge those interested in becoming a nurse to reflect upon their intentions as well as going into the career understanding that there will be myriad challenges that they encounter along the way. Despite these challenges though, recall that nurses frequently describe their job as rewarding and as a privilege.

How to not burn out

Another piece of advice speaks specifically to one of the biggest issues in the nursing profession, which is the exceptionally high rate of turnover due to stress and burnout. Nursing is frequently identified as a profession in which people experience burnout (Khamisa, Peltzer, & Oldenburg, 2013) so it is especially important to know ways in which to manage this. Nurse participants gave several pieces of advice on how to avoid burnout.

Avoid taking things personally

First, nurses warn against taking things personally and worrying too much about difficult situations. In a profession in which one is taking care of another person at their worst, it can be expected that patients may not always be pleasant. Jamie recommends that all new nurses read the book titled *The Four Agreements* (Ruiz & Mills, 2010) because it helped her to not take things personally. She says,

> I think that every nurse should have that because in the beginning of your career you take things so personal in from the patient and you and it just, sometimes it just breaks your heart, you know, like I'm just trying to help you and they're yelling at you but like you can't take it personal. It's their thing they're going through, like you don't know what kind of day they had and you just need to support them through that. That's probably one of the worst things that just popped into my head about being a nurse is that you're not, at first you're not prepared and there are good nurses that leave the profession because of that interaction that they just took it so personal. But no, it's not about you. It's all about them. And if you, if you think of that and if you read that book *Four Agreements* and life will be so much easier for the rest of your profession.

Additionally, when dealing with patients, Dawn advises to not let judgment affect care and to practice mindfulness. She states,

> What do you do when you have bad feelings about a patient, how do you not let that affect your care? Kind of that mindfulness aspect I guess. So then just being present and aware… Being nonjudgmental is another huge one. I sense myself getting sort of judgmental and how you kind of handle that and deal with that and reflect on it. So I feel, I think that that's probably the hugest part is just that reflection that it has to continue and on, like we do it all the time in nursing school, but you really have to keep doing it the whole time, like in nursing. So it's something I work on with my students… A lot of nurses aren't being present and they're judgmental and in the end it affects patient outcomes…Like if you're [practicing mindfulness], you don't have that burnout and that stress… [In the class I teach] we talk a lot about trigger behaviors. Like when you automatically, for instance, some families can't be at the bedside and to our students they

> are like appalled by that. But you know, I challenge them. I'm like 'Think about the other side, like does mom have other kids, does dad work? You know, they probably have to work to pay the bills.' So it's kind of just challenging that to see the other side I guess like it's not just one sided. I tell them kind of my motto is, is that if you judge a book by its cover, you miss a really good story.

Dawn says many nurses struggle with judging patients and getting caught up in the moment, which can lead to stress and burnout, but practicing mindfulness is not only something she has found to be helpful for her and those she knows, the benefits of mindfulness in health care professions have been well documented in the research literature (Irving, Dobkin, & Park, 2009). Stephanie also advises practicing mindfulness and recalls something that she learned from her manager, which is to identify "three good things" that happened during her shift. She says, "almost everyday I'm forced to look at my profession and say, 'Oh wow. Like those are three cool things that I saw happen today.'" In addition to avoiding dwelling on the negative aspects and instead focusing on three positives each day, she recommends looking at the bigger picture and not fixating on moments when she feels overwhelmed. Carlos adds that when feeling overwhelmed, to not panic and remember "your skills will come." Thinking critically when something does not seem right and "rolling with the punches" will help a new nurse to get better over time.

Seek support and ask for help

Another way in which nurse participants advised other nurses to prevent burnout is to reach out to others when needed. Andrea tells her nursing students,

> Don't give up because you will feel like for probably the first six months to a year that you have no clue what you're doing. You will go home every night and pray, 'please

> don't let me have killed anybody. Please let all these patients be okay when I come back the next day.' And you just kind of feel like, 'what did they teach me in nursing school? Because I don't think it was anything.' And I just tell them, I'm like, you know, don't give up. It will get better. Eventually. Every day you'll come in and you'll feel a little bit better until eventually you realize, huh, I kinda know what I'm doing. Like you start feeling confidence, confidence will come with time. And I just encouraged them to like take care of yourself, talk to people. You know, don't kind of hold that all in, but don't feel bad because it is a learning process because I wish somebody had told me that back then because there isn't many times of like, 'why am I here? Like, why am I doing this?' and I, you know, I think they need to know it will get better because sometimes when you're in the midst of that you're like, 'I just don't think it's getting better.'

She recommends especially to new nurses to talk to other people about what they are feeling so that stress does not build up and burn them out. Samantha suggests nursing students to "Ask for help often and as much as necessary. Even if people are busy and it doesn't look like they have time to help you. If you need help, ask for help." She also encourages past students to come back to her if they are hating their job and she will talk with them about other options in nursing. In addition to speaking with other nurses when feeling stressed out, Pam advises others to make time for friends. She states,

> I think scheduling time, like not just saying 'Oh I'm going to hang out with so and so, you know, this Thursday night' being like, 'No, we're meeting for dinner at 6:30.' Like really building that into your schedule because I feel like otherwise if it's—I mean there is fluidity within that but yet I'm really making a conscious effort to make that time with people from work and outside of work so that you don't get burnt out… But I feel like

> really kind of diversifying your circle and making time for each of those aspects outside of work is huge… But I feel like having that scheduled time just really makes it. Because that's, I mean if you are having a bad day, that's something to look forward to. And if you're having a great day, like you can go tell them… it's rewarding in and of itself. So I feel like having that on both sides, is important.

In addition to having a circle of friends to schedule time to relax with and maintain a health work-life balance, Pam also recommends having a couple close trusted friends to vent to when needed. She says of course because of patient protection laws she cannot provide specific information but she can vent about general situations.

Take education seriously

Third, advice that some nurses have given specifically to nursing students is to take education seriously. Kim says that education does not necessarily make someone more intelligent, but she adds, "what is does do is it definitely guarantees that there's probably going to be some doors open to you that would not be there if you didn't have that education." Similarly, Jamie stresses getting at least a bachelor's degree. Although she says, "If you're in a pinch for time and money, getting your associates degree first and then working for a hospital that will help you with your load going back," which is what she did, but she adds that "there's no way of getting around it anymore" in getting a bachelor's degree, because of the critical thinking and other skills it teaches. Lindsay also recommends taking education seriously as she wishes she would have done early on. Now that she is getting her master's degree she is paying more attention and studying hard, but she said when she was 18 and just out of high school she did not take it as seriously.

However, even though the nurses above stress putting a good deal of effort and attention into coursework, other nurses remind us that it is not the "be all and end all." Morgan, who trains other nurses, recommends not stressing out all four years in school but instead try to enjoy it and not miss out on other opportunities because "at the end of the day, I mean as long as you pass your [final examinations], like you do get to be a nurse and then the actual learning comes when you get your first job and you get trained." Natasha, a nursing professor, also tells her students something similar. She shares a common piece of advice she gives to students:

> If you get into med-surg and you don't like bedside nursing, get through the class. All you have to do is get through the class. You don't ever have to work in a hospital where you come into the nursing home and you don't like old people, get through the class and then you can go work for pediatrics or you can go be an OB nurse or whatever your passion is but for now you just have to get through the class and it's okay.

The latter advice may be helpful for nursing students who feel stressed and overwhelmed by nursing school, as illustrated earlier in the first research question findings where nursing students come to online spaces to ask advice related to the difficulties of nursing school.

Units that everyone should work

Nurse participants discussed their early trajectories when they first came out of nursing school and what was helpful for them in terms of experiences and units in which they worked, and they believe new nurses should undergo similar experiences. However, it was also mentioned above by a nurse that older nurses should move away from the culture of telling newer nurses that they should follow the same path to keep with tradition. Therefore, this section provides some advice in terms of opportunities that have been helpful for other nurses that may

be helpful if a new nurse is looking to gain experience, while acknowledging that there is not one 'correct path' that a nurse must follow in order to be successful or happy.

First, several nurse participants suggest working as a tech or shadow nurses in order to get hospital experience. Sophia likes to share her experience with nursing students and those considering nursing:

> If you have the opportunity, go get a job in a hospital. Go work with people, go see what they do… When I was in nursing school, you know, we started off and when I went to nursing school we didn't have the crisis of space that we have now. So all of our clinicals were in hospitals. Whereas now our sophomores start out in nursing homes and they don't enter the hospital until junior year because there's just not space, so they learn all the bed, bath, and touching people and vital signs on nursing home patients instead of hospital patients… So I'd already been working as a tech in the ER. I was already used to managing a whole slew of tasks and patients… the summer between my two years, there weren't enough hours in the ER. So I went up to the med-surg unit and say, 'Hey, could you use an extra hand?' 'Oh, absolutely, we can use you.' So I worked a ton up there and I actually got to interact with the nurses and the patients and see what the flow was like and it was so much more interesting than what school presented to me. And so I came to really like it and that's where my first job was, was on a med-surg unit. So that's what I tell people. Go work. Touch, make sure you can touch people.

Amelia was also glad that she worked as a tech in a hospital before she graduated because it made her transition much easier in terms of not being nervous going into a patient's room and how to manage time effectively. Sandra also says it is important to shadow different nursing

roles before getting on the job so you know what to expect. This is an important piece of advice given above findings that unmet expectations play a role in nurse turnover.

Second, nurse participants recommend working in different units and doing different clinicals in order to gain valuable experience and find the best fit. Carrie says, "My advice to [students] is when they do clinicals, try to do a variety of different areas because it's important to know what you want, but it's just as important to know what you don't want." Denise gives similar advice for nurses once they start the job:

> You're gonna have to do some odd shifts. You're gonna have to figure out what you want to do… You need to get your med-surg background first. I do tell everybody that for sure. And then go from there, you know, work on med-surg for a year, probably two to be safe, but then go from there and then branch out… Really good solid background, have a little bit of everything first. And then decide if you really want to specialize, you know, don't just rush into something and then decide you hate it. You know, work nights, cause you get a little more responsibility when you work nights, you get a little more crazy patients too. And the dark side of nursing a little bit more and you know, you need to kind of be a little bit of everything, a little less supervision I guess is too… you need to have everything not handed to you. So, you know, I think that's the best way to do it.

Several other nurse recommend similar courses of action: to work night shifts, to work in med-surg and other units to gain a variety of skills, and then after trying things out for a couple of years, a new nurse will be better poised to decide what interests them the most.

Finding your best fit

A theme that has been mentioned above is the notion of 'finding your best fit.' This is something that many nurse participants spoke about in terms of why they switched jobs several

times throughout their career as well as something they speak to nursing students and people considering nursing as a career. Given the high turnover rate in nursing, it is no surprise that this advice is helpful when given from nurses who are satisfied with their jobs with no intentions of leaving the nursing profession. Several nurses advise others to find their fit in various ways. For example, Vanessa says it requires "some soul searching" to determine why someone wants to be a nurse in the first place. She says, "If you want to become a nurse because you're going to make a lot of money or because you mom and dad want you to be; those are two worst reasons why you'd go into nursing." Monica suggests thinking about "How do you want to spend your time?" and "What kind of life do you want to have?" She adds, "So figure out how you like to live and then try to find the nursing spot for that because there probably is one." Dave supports this point as well, stating,

> I've had plenty of other friends that have done just totally different things in nursing from the nurse practitioner, to nurse anesthetist, to nurse midwives, to critical care nurse practitioners, and family nurse practitioners and stuff like that and just all the different things that they get to do. So it's kinda like one of those things is like, wow, once you figure out what kind of really trips your trigger for lack of better terms that you can actually, you can go after that. If you want to be a mental health nurse practitioner, you can do that. If you really liked psych, that's great. You know, and sometimes it's people that could be as simple as I really want to travel. So they'll become a travel nurse and they get to travel. So it's really so versatile and it's such a—just so many opportunities out there.

However, when deciding the area in which a nurse wants to go, Ashley recommends being open to considering an area that does not seem at first appealing. She learned this lesson firsthand

when she applied to the emergency department only to find that they did not take new graduates. When a connection in the hospital set her up with an interview for the neurosurgical unit, she says, “I would never have gone that route, but I’ve never even considered that.” She adds, “I'm just asking to please be open minded because you have no idea. I never thought I'd like neuro. Just the opposite; that became my passion and still is so you don't know so be open minded.” In other words, new nurses should try a variety of areas including ones that they may not be interested in, because it may just become their passion.

Influence of Nurses

The influence of nurses on each other cannot be ignored. The way that nurses perform their work and how they perceive their team, organization, and the profession as a whole is largely due to other nurses with which they work and have met along the way. Research question three asked: *How have previous interactions with other nurses influenced nurses’ perceptions of identification with various targets both before and after becoming a nurse?* Individual interview data provide understanding of various ways in which nurses have – both positively and negatively – influenced each other. Stories about other nurses revealed themes including nurses who provided encouragement and support, were good influences in how nurse participants wanted to be as nurses themselves, and bad nurses who showed others how not to behave. These influential nurses were encountered not only on the job but there were some who participants met even before choosing a nursing career that made a lasting impact in their lives.

Early Encouragement

Some nurses recall other nurses early on in school and when they first entered the profession who encouraged them in a memorable way. Sharla remembers several nurses who

were instrumental in building her confidence and supporting her as she learned to become a great nurse. She had some instructors in nursing school who "really just loved on me and gave me a little bit of confidence that I didn't have." She also remembers one nurse in particular at her first pediatric job who recognized Sharla's self-esteem and confidence was lacking. This nurse said to her later, "I knew you were going to be an amazing nurse and I knew you were going to do big things. I just needed to coddle you for a little bit. And then I had to let you fly." She says these nurses and other mentors she's had at each of her positions took the time to speak with her and guide her, and they are responsible for making her the nurse she is today as she tries to do the same for other nurses. Natasha also gives credit to a mentor she had in nursing school who helped her to gain confidence. She says this mentor "has made a complete difference as to why I'm still here and why I like the job." A nurse that Rachel shadowed early on also made a complete difference in her career. At the time, she had previously worked in education and training and was not sure that she liked nursing or wanted to be a nurse at all. But then when she shadowed a "delightful" nurse who showed her around, she recalls, "He said 'The main thing you have to remember about nursing is you're always teaching' and that was what made me realize I could like nursing." This was a turning point for her that led to her career in nursing.

Other nurses also recall good advice and help from other nurses which shaped their careers. For example, Sienna remembers some very helpful advice early in her career during a time when she was having a difficult time working in a pediatric intensive care unit. She says one of the nurses orienting her on the unit said to her, "When we stop doing things *for* the patient and start doing them *to* the patient, that's when you need to be real with the family." Sienna comments, "I really held onto that because I think there's worse things than dying and just continuing to do procedure after procedure on patients that's futile…so that really shapes like

how I look at nursing and just life in general." She also reflects on a nurse who helped her when she found herself getting jaded from working in an ER and people taking advantage of and using the ER inappropriately. She remembers the nurse telling her, "It wasn't my job to decide whether they needed to be there or not, my job was to take care of them…as a human being, as a whole person and not just whatever it was they were coming in for." Sienna says, "That really stuck with me too, just that sometimes we see things on the surface, but there's just a lot more going on." These bits of wisdom and guidance, however small they seem, often stay with new nurses as they are struggling early on in their careers. This early encouragement for them, they indicate, gives them confidence to move forward in their career when they may not have otherwise.

Positive Influences

Sharla's example above not only described nurse mentors who helped to encourage her, but they inspired her to treat other new nurses well. Other nurse participants also talked about nurses who served as positive influences in that the nurse participant wanted to emulate. For example, Ashley remembers two nursing professors from nearly 30 years ago who inspired her in this way. She says,

> I can think of all of two faculty that I can say truly had an impact on me and they had the same personality traits, just warm, approachable, seem like they genuinely cared. Not to say the others didn't, but that stuck with me as I moved on in my career thinking if I'm ever in a position to teach or help, here's how I want to be. I would want to emulate how they work.

Now that she herself is a nursing professor, these nurses from early on stay especially close to her mind.

Participants also recall nurses who were similar to them in ways, which inspired them to follow a similar path. For example, Tiffany thinks about her first preceptor when she first graduated, who she still considers a good friend to this day. She describes some things she has learned from this preceptor:

> She's been a very awesome mentor. And she's totally just like me, or I'm just like her, I guess I should say, in the aspect that nursing is something that requires compassion and caring and you're there to help the patient and be there for them and not just do the tasks and get in and get out, which I feel a lot of the way that nursing is going, that we're expected to do what we need to do and move on. And you know, she taught me to take the time to listen to the patient and do the extra things like fluff a pillow and you know, give them a nice cold ice water because a lot of times they'll have water by their beds but ice melted and it's all warm again. So freshening that up and talking to them and actually sitting and listening, you know, and I watch all these new grads that I see being trained and they walk in the room and they don't even look at the patient and they put gloves on and I'm sorry, but you don't need a pair of gloves to talk to a patient, you know, you don't even need to listen to their heart and lungs, you know, when you have to touch their feet or do something else. Yes, I get it… But you know that that touch is hugely important when you don't feel well and aren't doing, you know, when you're in the hospital. And human touch is huge and something that my preceptor reiterated.

Tiffany was immediately drawn to this nurse because they had similar mindsets, which helped her to understand and really listen to what she said. Similarly, Tanisha felt inspired by a nurse who was similar to her in that they both came to America from countries in Asia. Tanisha says

that when she worked at a hospital right after she came to America she met this nurse, who had a master's degree and was the director of the center where she worked. Tanisha says,

> From that moment I was wondering, I can be a chart nurse or get higher degree like master's degree in nursing, that's why I came here working very hard. So my director told me to be a chart nurse and now I'm applying for a master's degree in nursing school… So at the beginning I wasn't confident to get a higher degree because you know, different culture, different language, we're perceived differently, you know. But working with that girl I saw I can do that too. Sometimes you know people around you inspire you and give you a pull to work hard, to have more power, more knowledge, and have position.

These and other examples from nurse participants highlight the influence in which homophilous nurse mentors can have on new nurses.

Nurse participants also recall dramatic instances in which nurse mentors were there. For Dawn, she shares a moment from working with a nurse and mentor who she says shaped her the most:

> I just remember the first time when I was working at [hospital], we had cancer patients and there was a patient that was, like he was supposed to go in the next day on hospice and we knew he was going to pass away, but obviously it happened faster than we thought and I just remember calling her. Cause it was the first time that it had happened for me honestly. And you know, her and the physician too was amazing. Her coming in and being like, 'you did everything right' and how she talked to the family and how she just listened to them. She didn't say probably like the wrong things that you're afraid of saying. That's probably like my, one of my strongest memories. It was just her being there, not just for me but like for the family too.

These moments, especially for new nurses, help them to observe and make sense of how to handle future situations when they are on their own.

What Not to Do

Most nurses can remember at least one nurse that helped to encourage them and served as a positive influence along the way, but some nurses also have come across other nurses whose behavior was so poor that it inspired them in what not to do. For some, like Sophia, meeting nurses like this occurred outside of work. She describes her experience when her father passed away in the hospital:

> The way we were treated by those nurses definitely shaped the kind of nurse I was because they were hiding things from us, they were not open and I thought this is not the way to do things… But that experience definitely shaped a lot of what I do… One of the experiences we had with my dad was he didn't get to sleep at night because he got interrupted every hour and so as a nurse I worked really hard to get my patients four uninterrupted hours at night because it's important for rest, but that takes a lot of time management and a lot of skill and juggling to make that happen for all of your patients… So I've always guided my practice by I'm not going to do what these people did and hopefully I land in what the other people did.

This experience, along with meeting other bad nurses along the way, directly shaped the way Sophia practices nursing by showing her ways that she should avoid doing what bothered her so much while her father was in the hospital. Other nurses experienced similar feelings about some unpleasant nurses when they first started their jobs. For Andrea, the most impactful nurse she met was one when she first became a nurse. She says,

> She was a good nurse, but she was not one of those nurses that really had that good interpersonal communication going on. And I just remember, I mean, she was kind of almost like a little bit of a bully, I mean she would just bark out orders…I think that shaped me in the fact that I tried never to do that to other people, to be that way.

Even though Andrea believed this nurse was good at her job, no one wanted to be around her, and her unpleasant demeanor left a lasting impression. However, Rachel had an experience with some bad nurses who truly did not care about patients either. She recalls a situation working for a state health survey agency when an assisted living facility was destroyed from a storm and the patients, who had limited mental health and were on Medicaid, needed to be moved somewhere else. When other nursing homes kept refusing to take the patients, Rachel was not ready to give up. However, she recalls the interaction with her coworkers next:

> A couple of my coworkers say, 'Of course nobody's going to take them.' And I looked at them, I said, 'How's that okay?' and they say, 'Come on [Rachel], let's go. There's nothing else we could do here.' I said 'No no no no. We're not leaving, that's not the way this is going down.' And they, you know, got a little uncomfortable and they ended up leaving the next day and I stayed and it was a mess. And I just remember having a rather intense conversation and telling them, I said, 'Okay, I guess we can put a price on human life then, it's basically what you're all saying really.'

She was so appalled by the situation in which her coworkers did not share the same concern over these patients because the patients were dirty, had limited mental health, and did not have money. She said that what her coworkers had said had really shaped her career.

Nurse participants recount, as told in some of the examples above, some ways in which other nurses have helped to shape their careers and perceptions of their work. From these other

nurses, both good and bad, they learned how to treat patients and other coworkers and even how to take care of themselves. Some of these interactions shaped their perceptions of their work team, by bringing them closer to coworkers or, in the case of some negative experiences, to avoid certain coworkers. Some experiences helped to shape perceptions of what working in a certain hospital or organization is like, while others, often for participants who can recall several experiences over their careers, have given them a sense of what nurses in general are like within the larger profession. In some ways, these interactions contribute to how strongly they may identify with their work team, organization, and profession. Some of these examples are provided in the next section.

Nurse Identification Targets

Previous research on nurses have only grazed the surface of understanding how nurses identify with their work team, organization, and profession, and much of this research conflates these targets or only focuses on one. Research question four asked: *With which target(s) of identification do nurses most strongly identify, and why?* Data from individual interviews and questionnaires provide answers.

Survey participants answered questions which measured how strongly they feel attached to three occupational targets: their work team, the organization for which they work, and the overall nursing profession. Each target included the same six questions and identification was measured on a five-point scale, with 1 indicating strongly disagree with the statements or low identification and 5 indicating strongly agree with the statements or high identification. Nurse participants indicated that they identify most strongly with their work team ($M = 4.10$, $SD = .61$), followed by the nursing profession ($M = 3.74$, $SD = .89$), and then their organization ($M = 3.23$, $SD = .97$). It is worth noting here that although organizational climate and culture may be most

easily associated with the organization itself, they can be bolstered through interactions with one's immediate work group, not just with the organization itself (e.g., Gershon et al., 2004; Malloy et al., 2009; Poghosyan et al., 2013; Schneider et al., 2013). In other words, these findings still suggest that organizational climate and culture matter and have influence over a number of nurse job outcomes as noted in Chapter Two.

Correlations were computed between team and organizational identification, team and professional identification, and organizational and professional identification. Findings show that each of the pairs of identification variables are strongly correlated. Team identification is strongly correlated with organizational identification, $r(287) = .418$, $p = .00$. Team identification is also strongly correlated with professional identification, $r(287) = .475$, $p = .00$. Finally, organizational identification is strongly correlated with professional identification, $r(287) = .370$, $p = .00$. These findings suggest that there is a relationship between these three identification targets for nurses and that they all may influence each other positively. This supports existing research that found a positive relationship between organizational identification with both occupational and workgroup identification for nurses (Marique & Stinglhamber, 2011).

Next, I conducted paired samples t-tests to determine if there are significant differences for nurses between each identification target. Findings indicate significant differences between all three targets: team and organizational identification, $t(288) = 16.258$, $p = .00$; team and professional identification, $t(288) = 7.559$, $p = .00$; and organizational and professional identification, $t(288) = -8.211$, $p = .00$. These findings support existing research that suggests nurses identify more strongly with their profession than their organization (Apker & Fox, 2002); this finding is not surprising considering that nurses tend to change organizations several times throughout their nursing career.

Further, I conducted analysis of variance (ANOVA) tests to determine if there were any differences between identification targets and demographic information. Apker and Fox (2002) did not find any difference between professional and organizational identification with age, time as a nurse, and time in their organization, but Trybou et al. (2014) found that nurses who have worked over ten years identify more strongly than less tenured nurses with the profession and their organization. Similarly to Apker and Fox's findings, there was no significant relationship between any of the three identification targets in my study with time as a nurse or time in their current organization. Additionally, no relationship existed between age and any identification targets when considering age as a continuous variable. However, I then divided participant age into four groups which follows a normal distribution curve: 24 years and younger ($N = 64$, 16.9%), 25-34 years ($N = 201$, 53.2%), 35-44 years ($N = 79$, 20.9%), and 45 years and older ($N = 34$, 9%). One-way between subjects ANOVA results indicated that a significant difference between age group and professional identification, [$F(3, 284) = 5.08$, $p = .002$]. Post hoc comparisons using the Tukey HSD test indicated that the mean for professional identification for nurses 24 years old or younger ($M = 4.16$, $SD = .67$) was significantly higher than nurses between 25-34 years ($M = 3.64$, $SD = .90$) and nurses 45 years or older ($M = 3.47$, $SD = .96$).

Additionally, I was interested in determining if identification was related to licensure, hours worked per week, and whether or not nurses worked in a hospital or other organization. First, a one-way between-subjects ANOVA indicated no significant differences between any of the three identification targets and nurse licensure. However, as noted previously, the majority of participants ($N = 342$) identified themselves as Registered Nurses (RNs), so these results could differ in datasets where there are larger numbers of participants with different licensures. For example, Trybou et al. (2014) noted that RNs identified more strongly that nursing assistants

both in organizational and professional identification. Second, a one-way between-subjects ANOVA indicated no significant differences between any identification targets and number of hours worked per week. Third, an independent samples t-test indicated that there is a significant difference in organizational identification between nurses who work solely in a hospital (M = 3.086, SD = .956) and nurses who work in a non-hospital organization (M = 3.769, SD = .842), $t(257) = -5.13$, $p = .00$. These results suggest that hospital nurses identify with their organization less strongly than nurses who work in non-hospital organizations. This is supported by interview data, as many nurses currently working in a hospital stated that they did not plan to stay there for long and nurses who had already left hospital settings commented that they were unhappy with the stressors of working in a hospital.

Some of the above findings align with the scant research which has already been conducted on nurse identification. However, a unique contribution the current study makes is to provide qualitative explanations of *why* nurses identify with one occupational target over another. As the above findings show, nurses tend to identify more strongly with their profession than their organization, but they identify most strongly with their work team over other targets. Next, I illustrate some reasons in which nurse participants feel they identify more strongly with one of these three targets. I will also highlight examples in which nurses feel their identifications have changed over time as well as some intersections between occupational targets and their personal identification.

Work Team Identification

Findings from questionnaires and interviews indicate that more nurses identify most strongly with their immediate work team than with other occupational targets. Many interview participants said they identified strongest with their work team because they feel close with their

coworkers and have strong interpersonal bonds with them. For example, Amelia has spent a lot of time with her coworkers on her night shifts, and she feels so strongly attached to them that it overrides her desire to get a new job. She says,

> I had thought about applying to other hospitals… but I didn't want to leave my coworkers, like I wanted to leave [state] but I was nervous that I would get somewhere and then really not enjoy working with a specific team. And that can completely ruin your work life when you don't get along with coworkers.

Indeed, people often spend the most time at work with their immediate work team members so having a good relationship with those people plays a large role in satisfaction at work. Sharla also feels closest to her work team because in her words, "my work team, they're like my siblings, and then the organization… are like my aunts or uncles and you're committed to them but you're usually not as attached to them as you are your siblings." Natasha, a nursing professor, also feels most strongly connected to her work team but for a different reason. She states,

> I feel like people sort of come to me for advice or… I've met with other faculty members often to help mentor them and how to prepare their documents or just things of that nature. So I guess I just, I feel a little bit more needed I guess... That sounds silly, but like I guess I just feel like I have purpose, if that makes sense. Like I have a purpose when I'm there and it's not simply just for teaching and my students and it's not simply for my own self-promotion or anything of that nature, but like the other people actually have interest in what I have to say or have interest in me helping them in some way to promote them or whatever network, you know, get them connected with somebody networking wise or something.

She adds that she feels most connected to the work team because she has a say in what happens and can feel that she is needed within the work team compared to the overall organization or profession. Many nurses feel most connected with their work team or specifically with the connections that they have formed with the members of their work team. However, without steady team members, nurses may feel less attached to the team. This is the case for Jamie, an emergency room nurse, who says she identifies least with her team because it is constantly changing due to the high turnover rate within the ER. In cases where a nurse does not have consistent coworkers, nurses may feel more attached to their organization, which is described next.

Organizational Identification

Although nurses tend to identify less strongly with their organization than their work team, some nurses do indicate feeling strongest toward their organization. One reason for this is that nurses sometimes switch units within a hospital but may stay in that hospital for their career. In Patty's case, she identifies most strongly with her organization simply because she has been there the longest. Similar to Jamie's example above, Andrea identifies with her organization more than her work team because of a lack of team members. In her case though, her actual work team is so small so she often interacts and has formed relationships with many other people within her organization. For her, she does not consider her work team and organization to be separate because she feels "like we're one big team." Kim similarly feels like she cannot separate her work team and organization, and states,

> I do not see them as separate. We are the same thing because we're working towards—we can't make any decisions where we're not considering the reputation of the organization that we work with. We may want to go in a direction as a team, but if that is not the

> persona that our organization wants to put out there, then we better go find another place. Now we can mumble and grumble within ourselves, but when we put on our faces for our organization, we have got to promote that organization to the full extent because we have to believe that the work we're doing is really, really good and important and necessary. If you put down your own organization, it's basically demeaning your own work.

This statement indicates a high level of organizational identification because it highlights standing on a united front with one's organization (Mael & Ashforth, 1992).

Professional Identification

Nurse participants also provided some reasons why they may identify strongly with the nursing profession as a whole. Although many nurses feel like they are "a small fish in this huge pond," as Sharla says, others feel that the nursing profession stays with them no matter where they go. Sandra identifies most strongly with the profession because "I'm a nurse when I'm on the clock, when I'm off the clock, even just with how I care for my family and my friends, there's always going to be that kind of nursing characteristics that come out." Additionally, she says, "There are so many nurses, so it's like you can identify with them across the country. I could be on vacation somewhere and meet a nurse." She even recalls a recent interaction with a nurse she met in a restaurant in another state and they talked during dinner and made a connection. Further, some nurses feel the profession is with them wherever they go because it is more constant or fixed than any work team or organization alone. As Dawn says, "[Organization] may leave and like my colleagues may leave but I feel like the nursing is always going to be there" and she can always do her job and model behavior to new nurses no matter where they go. Similarly, Rachel says, "I could leave the agency and still have a job. I could leave my work friends and still have a job." Contrary to Amelia's earlier comment, where she resisted switching jobs because she was

so attached to her work team, other nurses were given different advice. For example, even though Stephanie acknowledges “the relationships make or break your working environment,” and she herself struggled with leaving a work team that she really loved for a better career opportunity, she was told by another nurse, “Don’t stay for the people because the people won’t stay for you.” She said that stayed with her and is the reason why she roots her identity with the profession instead of a work team or organization. Additionally, some believe that nursing is one of those professions which carries a stronger professional identification than other jobs. For example, Carlos notes,

> As far as the nursing profession, I don't know, there is just something about I am a nurse and I've always hypothesized that there are certain jobs where you are this thing, you are a nurse, you are a marine, you are a firefighter. Like it’s just who you are.

Indeed, many nurses indicate that being a nurse aligns strongly with their core values, which will be described in further detail below. However, some nurses explain that the strength of their identification with one target has changed over time depending on specific circumstances. Some examples are provided next.

Identifications Changing Over Time

Understandably, identifications may change over time as one becomes closer or more distant with coworkers, as they work at the same organization over a period of time, or a number of other reasons. Some nurse participants have indicated that two main reasons why their own identifications with an occupational target include either a changing mission or policy or a change in their own life. For Jessica, she felt very strongly attached to the organization she started at ten years ago, but after about four years when decisions about patient care had changed, it became a “deal breaker” for her. She explains in detail,

So this has been a really, really super stressful and sad situation for me over the last couple of years. But so starting maybe, I don't know, four years ago or so… [the other NP and I] began to really have trouble with some of the decisions that they were making administratively. Not only us, but many other providers, especially people that have been there, I mean partly because they'd been there a long time, but also just because they began to make decisions that were more focused on the patients as these units that they needed to, you know, service versus think about the clinics as a community place where people could come in and be part of a, you know, like they felt like that was a part of, they were sort of a family kind of thing... And so over time they began to use the nurse practitioners interchangeably. That was a huge issue. So they would move practitioners from one practice to another. Which was very disruptive to patient practitioner relationships. I mean, it just severed them basically. So that was a huge problem. We tried to work with them about it. We tried to talk with them about it and they just really, you know, they just weren't interested. In fact, they just didn't want to talk to us at all about it. And then they put in a call center, which meant that instead of the patient being able to reach directly the receptionist at their clinic, they lived in [town], if they called the number what they got was a person in [another town] that was at a call center. They didn't know them… for our patients, first of all, got vastly complicated weird stuff going on. They often don't have minutes on their phones. They can't, they have to try to explain what's going on for them or they know they want to see somebody but they don't remember their name. And you know, it's like there were just all kinds of reasons why, actually there was a study that the administration paid for to have done… And actually what they said was… for low income, it works best to have people call directly to their

> clinic and talk directly to people and that you scheduled them on a patient by patient basis. Like, in other words, you don't make the appointment three months in advance because they can't possibly say what they're going to be doing in three months or even where they're going to be living in three months. You have them call in the day before, two days before, three days before and make the appointment then because that's when they know what they're going to be able to actually do. And instead of taking the advice of that… that research that they'd had spent, we spent literally a year meeting every week with those [survey] people. And then they ended up starting a call center anyway. So they started a call center. That was another huge bone of contention. And then they had a policy where they wanted all children to see pediatric nurse practitioners. And that is a huge issue if patients don't speak Spanish. So there's a whole philosophy about seeing the whole family anyway, you know, that if you see the entire family then you have a better idea what's going on with those children because you know, their parents very well, you know, whatever. But anyway, at the least you want to have people who speak their language to see them. And so that was another issue that we had a lot of trouble about. So anyway, the upshot of it was that eventually the administration decided that they just needed to break the [town] clinic up. And so they took me out of the clinic… and I just ended up deciding that I needed to move on. It was super stressful, super heartbreaking for me.

It is clear that Jessica cares deeply for her patients and the mission of the organization before it had changed. But because of this experience, Jessica says that her allegiance has shifted to the profession as a whole and how to improve the profession. Similarly, other nurses grew apart from their organizations due to changes. For example, Natasha worked for an organization for

years and even had several positions within the organization but said "our management started to change and just their philosophy of the way we were going to handle patient care… and so I decided it was no longer for me." Since then, she has heard that management has changed again and is considering going back part-time because she loved the organization and patients but could not work under the changed mission.

In addition to a changing mission or policies, nurses also indicated becoming less attached to an occupational target because of personal changes. For example, Sienna used to identify strongly with her work in an ER because she enjoyed the fast-paced work, but now she prefers working in an office. Personal changes also include a nurse's interests or involvements changing which influences how they may feel about their work. For Tiffany, she would have identified more strongly with her profession one year ago, but now that she has become more involved on committees in her hospital, she feels more attached to the organization. She says,

> Knowing what I know and seeing how awesome our hospital is and what amazing things we do day in and day out over the whole hospital has been really cool. So I definitely feel a little more connected to the hospital than I did previously.

Morgan's identification with the overall profession is growing in a similar way as in Tiffany's example, because she is trying to understand the larger scope of nursing and become more in tune with evidence-based practice research and become more involved in the nursing community.

Intersections Between Occupational Targets and Personal Identification

In addition to various occupational targets of identification, it is important to consider a nurse's personal identifications and how it may align or conflict with their occupational identifications. Research on the connection between a nurse's personal and occupational

identifications indicate a positive relationship between the two in terms of prosocial behaviors (Cha, Chang, & Kim, 2014) and personal goals (Ashforth & Mael, 1989), among others. Nurse participants indicated that their personal identifications aligned with occupational identifications in ways such that nursing aligns with their personal values, a deep connection with being a nurse, and their family and life schedules. Participants also indicated instances in which they feel their identifications conflict.

Aligning with personal values

Most nurse participants feel that their occupation aligns strongly with their personal values for a variety of reasons. For Stephanie, she says

> My root identity is in God… and I want to use my time, talent, and treasure to serve God and serve to people that he loves… and I feel like nursing is one of the coolest ways I that I can do that.

Others, like Pam, puts health as a top priority in her life and she finds nursing to be a great way to help others to have a "healthy mind, body, and soul." Dawn says that both nursing and her personal life align because both prioritize values of caring, compassion, and empathy. Additionally, many nurses feel that this work is their personal calling, like Monica, who says "Some people call it a calling and I know that word gets sort of loaded. I don't love that word, but I definitely feel that word." It seems for many nurses, they are able to find a variety of ways in which nursing fits well into their life by aligning with their personal goals and values.

A nurse will always be a nurse

Similarly to personal values, nurses frequently indicated that nursing aligns with their personal lives because they cannot disconnect from it. They feel so closely connected to their

work, perhaps finding it as a calling as indicated above, that it often flows over into their personal lives. Sienna says there is not much separation between the two because people will often ask her health-related questions outside of work. She adds, "You can't get away from it if people know that you're a nurse, you're a nurse 24 hours, there's really not a separation." This was a frequent comment from nurses, as they recount examples of when they have helped others outside of work. For instance, Andrea remembers a recent instance at church when a woman passed out and Andrea felt compelled to help. She says, "I will always be a nurse and then there's a lot of people that believe like, once you're a nurse you're always a nurse." Ashley says this is because "it affects how you think, how you deal with people. Like you're always doing an assessment without realizing…You can't turn it off." These sentiments were shared by many nurse participants, which suggests that perhaps a certain type of person chooses nursing because they want to help others and also that with this knowledge that nurses possess, they can carry this help over into their personal lives to care for people whenever needed.

Aligning with schedule

A third way in which nurse participants say nursing aligns strongly with their personal identifications is because it fits nicely within their lifestyle and schedule. For example, Tiffany says working night shift allows her to enjoy her job but also have time to spend with her family of five children. Similarly, Sandra says one reason she loves nursing is because it allows her to have a good work-life balance. Her current schedule works well for her life, it financially supports what she and her husband enjoy doing, and it will provide a good opportunity for her to start a family. For Sharla, even though she says she made her career a priority because her professional success was an important personal goal for her, she still manages to travel throughout the year, spend time with family and friends, and do other things she enjoys such as

attend Broadway shows. Nurse participants have a wide array of degrees, positions, and schedules, so no one single nursing schedule would align with each participant's needs. However, reiterating a point that has woven throughout these nurses' narratives, they have often had to try several different paths before arriving at one which they felt was a perfect "fit" for them. A benefit of a nursing career is that participants were able to find the combination of criteria which suited their needs.

Instances of conflict

The majority of nurse participants eagerly indicated that their work aligns well with their personal identifications; however, they also identified some ways in which there were conflict. For some nurses, they have not found a position which aligns well with their schedules as some nurses had mentioned above. For example, Jamie felt a conflict between work and life over the last year when she had hoped to spend more time at home during the Christmas holiday season, but when the flu struck their area hard and many nurses called off work, she found herself spending more time at work than she had hoped. She also mentions her schedule at times interfering with spending time with her husband or enjoying some of her hobbies such as hiking and fishing. Other nurses who work evening shifts mention ways in which this schedule is helpful at times but then other times when they cannot spend time with friends who work nine-to-five jobs. For Vanessa, the only time she found nursing to conflict with her personal beliefs was when she was asked to assist with an abortion, to which she declined for personal ethical reasons. Natasha says that her current position as a nursing profession aligns with her life perfectly, but sometimes she experiences a conflict when friends or family ask for medical help. She explains,

> I often get phone calls and texts and emails from people asking for medical advice. And so while I want to help, while that's my profession, there are times I just have to say 'I'm sorry, you need to go see your provider for that' or 'I'm sorry I can't prescribe outside of my job, so if you want to come see me there.'

In this example, this is not as much of a conflict between personal and occupational identifications as it is other people's unreasonable expectations of a nurse's boundaries. Overall, even if a nurse feels that their personal and occupational identifications align, they may still occasionally experience moments when it conflicts, which is expected in most occupations.

CHAPTER 5. DISCUSSION AND CONCLUSION

Although nursing is one of the most trusted and important professions in the United States, it is wrought with issues such as stress and high rates of turnover (Apker, Propp, & Ford, 2009). For these reasons and more, health care organizations must better understand how to retain their nurses and maintain their job satisfaction. Additionally, nurses themselves should learn not only how to cope with work stressors but also to find an area in nursing which best suits their career needs. Organizational identification serves an important function in this regard by helping to explain how nurses make sense of their work and identities through the work team and organization to which they belong, along with how they see themselves positioned within the larger nursing profession. This study furthermore acknowledges the influence of how perceptions of identification along with communication with other nurses help constitute turning points in nurses' careers and influence their career decisions. The results of this study highlight important theoretical and practical implications for understanding the interplay of nurse communication, turning points and career decisions, and identification.

This chapter outlines several contributions of this study. First, this study makes a number of theoretical contributions to identification, career communication, socialization, and turning points. Next, this study provides insight into how nurses construct meaning about their jobs and the influence of communicating with other nurses in guiding career decisions. Additionally, findings of this study provide information that may help health care organizations to retain nurses and reduce turnover, nurses to more effectively navigate the stressful work environment, and those considering nursing to have realistic expectations of the work. This study also offers methodological contributions by employing a novel mixed-methodological approach which combines interview, survey, and online data to holistically understand the interconnection of

nurse communication, turning points and career decisions, and identification. Finally, I discuss limitations of this study and future directions.

Theoretical Implications

This study makes several theoretical contributions. First, the study reveals that online spaces are an additional and important source of anticipatory and vocational socialization for individuals (in this study, nurses) in precarious workplace contexts. This study showed that nurses, who often face turbulent work environments, have begun to turn to online spaces to seek informational and emotional support, and are building online communities to fill gaps in communication within their physical work spaces. Second, this study extends understandings of anticipatory and vocational socialization by considering the addition of tensionality in (nurse) communication between professional peers. As nurse participants identify several issues which exist in the nursing profession today, I recognize that there are dichotomies within their communication which mimic the dichotomic nature of the issues they identify. In other words, while nurses recognize issues of equality and power within the profession, they still perpetuate these issues through communication with each other. Additionally, the very narratives they create about their work contributes to the unrealistic expectations new nurses have when they enter the profession. Third, this study unearths the dynamic interplay between anticipatory and vocational socialization and communication, and their influence on (nurses') occupational identifications. In this regard, the study contributes to Myers' and others' (e.g., Scott & Myers, 2010) work on socialization and identification by focusing on a profession which is known for having unique socialization processes, as displayed in nursing's culture of incivility and bullying. Fourth, this study underscores the connections/interdependence among team, organizational, and professional identification targets and that personal identification (identifications not related to

work) influences and is influenced by occupational identifications. In so doing, the study suggests that researchers must consider these targets separately but also consider how they may operate in conjunction with one another. This study provides qualitative examples why nurses may identify more strongly with one target over another, and how identifications can change over time. These are all described in more detail next.

Online Spaces as an Important Source for Socialization in Precarious Workplace Contexts

Nurses communicate in online spaces in a variety of ways and for a variety of reasons. Survey results indicate they most often use online discussion forums just to read what others say on the forums, and over half of survey participants said they come to get advice and to learn more about nursing. Sometimes nursing can be a lonely job if they do not get along with their coworkers or they feel like there are things at work that they cannot talk to others there about. Perhaps nurses are using these online spaces to expand their community of people who understand them; perhaps they are trying to feel closer to their profession by finding others across the world who do the same job as they do. They may not know who to turn to at their job for advice or maybe they are hesitant to speak to others about issues because it is a confidential issue or they do not want to seem incompetent. Interview participants mentioned that nurses often hesitate to ask questions in fear that they will seem incompetent to others, so online spaces may be an outlet for them to get help with their job without being judged by people they know and work with. Over 90% of the survey participants have asked questions on the discussion forums, which suggests that nurses are seeking an expanded community of nurses to which they can turn. Again, this implies that nurses may be hesitant to ask others at work these questions.

Additionally, analysis of online discussion posts also confirms that nurses are using online spaces for informational support and emotional support through the use of humor, sharing

experiences, venting, and getting/giving advice. As both interview participants and online posts indicated, the culture of bullying and "nurses eating their young" still exists widely which can hinder nurses from asking questions directly in the workplace. Online spaces provide not only a community of other supportive nurses but help reduce uncertainty related to work issues and questions. The use of online spaces to provide support, in a professional culture in which it is not always acceptable to ask questions or seek help, is an answer to some of the socialization and assimilation issues that nurses have encountered over time. According to Waldeck and Myers, "the ability to engage in communication that reduces one's uncertainties can reduce stress and result in a heightened state of organizational assimilation that ostensibly improves one's attachment and contributions to the organization and overall satisfaction" (2007, p. 326). Therefore, nurses seeking to reduce stress associated with uncertainty may turn to online spaces as an alternative to communicating directly with people at work, and these online spaces may even be doing some of the assimilation work for organizations. These findings also contribute to Jablin's (1985) and others' work on anticipatory and vocational socialization and extend what is known about how online communication offers an additional source for nurses to engage in socialization beyond sources like peers and family. This study suggests that sometimes nurses are more comfortable communicating online with "strangers" than those they know, perhaps in fear of nursing incivility or being thought of as incompetent by their peers, as previously mentioned. It will be interesting for researchers to note longitudinally how increased use of online spaces will impact nurse culture and communication.

The Role of Tensionality in Communication and Socialization

This study provides insight about how nurses construct meaning about their jobs and how these meanings can lead them to make career decisions. The social constructionist meta-

theoretical framework used in this study acknowledges that nurse perceptions of their work and identifications are constructed through communication with others (Davis & Cox, 1994; Gergen, 1985). These perceptions and meanings of being a nurse are shaped over time and provide a useful way of understanding how nurses' decisions to pursue a nursing career and move within their career are influenced by communicating with other nurses. The social constructionist approach also combines with social identity theory and self-categorization theory to explain how the strength and multiplicities of identification within nursing are constructed and shaped by other nurses, as demonstrated when nurses described memorable interactions that marked career changes. As Eisenberg (2008) notes, health care teams are socially constructed groups and the interplay of organizational and professional cultures, as well as social forces and hierarchical structures, shape these teams and how they work together. How nurses and other health care members communicate with each other is critical in forming the image of a nurse.

When nurse participants talked about their work, they identified a number of aspects about their job. They described what it is like to be a nurse and they talked about current problems the profession faces and what they believe accounts for the large amount of shortage and turnover in the profession. They shared their personal experiences in terms of memorable moments, expectations they had when they started nursing, and the reasons behind why they decided to become a nurse. They also addressed why some nurses believe their work is more often a "career" than just a "job" and they had various pieces of advice to give to new nurses. There were several points worth emphasizing because they reoccurred at multiple points during the interviews and/or highlight important facets of nursing work.

One topic that came up frequently is how nurses view the current trajectory of the nursing profession in terms of issues that exist and changes that need to be made. There are clear

disjointments and disagreements within the profession in ways which relate to identity, entry-level requirements, and policies. Nurses often noted that they struggle with establishing a unified identity of what nursing should be and what degrees should be acceptable. Because there is such a large range in education between nurses working on the floor, nurses believe there is a spectrum of professional behaviors and knowledge displayed, which also contributes to the public's skewed perception of nurses. Nurses struggle with outdated views of nursing, noting they are often still viewed through a "handmaiden" lens, which can explain not only the lack of respect they sometimes receive but also why the profession is still over 90% women-dominated (Certified Nurses Day, 2019). Buzzanell and Goldzwig (1991) note that conceptualizations of careers are established and maintained through language and how members talk about them, which explains how views and identities of nursing have been perpetuated over time. Additionally, there are competing dichotomies in how nurses communicate about their jobs which speaks to the disjointed nature of the profession. For example, while nurses state that they are a well-respected profession, they also state that an issue exists with lack of respect from doctors, patients, the public, and even themselves. Further, while they speak of the benefits of having a broad range of opportunities within nursing, they list this broadness as a contributing factor to them being disjointed.

Although the earliest constructs of nurses in America have changed over time, outdated views of nursing still exist. Fox and Abrahamson (2009) note that some current views of nurses include "caring do-gooders," "angels of mercy," and "having wildly exciting lives" (p. 241), but nurse participants indicated struggling with some of these views, as one nurse even stated, "I can't stand that message because I don't want the angel nurse. I was the smart nurse" and explains how these views "overshadows nurses' intelligence and skill." Changing currently

constructed images of nurses would be beneficial in promoting "a positive, yet realistic view of nursing as a sensible career path" and it can also "assist in transforming nursing's public image from feel-good task, to rewarding profession" (Fox & Abrahamson, 2009, p. 242). However, one challenge in changing the image of a nurse exists in how traditional hierarchical bias in health care prevents nursing from being seen by the public as rewarding (Eisenberg, 2008). It is important to note though that some of these harmful views of nursing are constructed and maintained by nurses themselves. Findings identify ways in which nurses have experienced bullying and hegemonic behaviors which contribute to the very oppression they are seeking to overcome. An additional point in these findings is that there is a clear generational gap with how nurses communicate about their jobs. Older nurses, approximately 50 years or older, believe that newer nurses, which they sometimes refer to as millennials specifically, are less satisfied with their jobs than the older generations and expect to not have to tolerate certain demands.

Additionally, nurses noted their ability to take more responsibility as well as the need to gain more power within the health care community, but nurses themselves also perpetuate their constraints to gaining power. This issue exists in what Buzzanell and Goldzwig describe as "Through implicit acceptance of organizational control and hierarchy, individuals grant immense career decision-making power to organizations," and further, "They also invest themselves in a preestablished system, part of which is a common understanding of career paths" (1991, p. 472). They argue that whether assessments of a member's potential is accurate or not, careers are often controlled by these assessments from others along with established norms. In other words, although nurses have identified problems within the profession, they exist because they are still accepted and communicated, even unintentionally, by nurses themselves and other health care workers. The dichotomous nature of nurse communication about issues within the profession

extends research literature on anticipatory and vocational socialization by considering how these issues are pointed out while also perpetuated, highlighting the complexities in the relationship between the nurse and the organization/profession.

It was also clear that memorable moments and opportunities played a large role in shaping both how nurses view and talk about their work as well as how they made decisions within their careers. Many nurse interview participants recalled interactions with patients and coworkers which stayed in their memories for their entire careers, sometimes even more than 30 years later. Nurses also noted moments which shaped their whole career trajectory, whether it was a change in family needs, a bad manager or work environment, or an unexpected opportunity that arose. To the point of family needs and because the majority of nurses are women, many nurses may temporarily leave their job or switch roles in their job to have children. This may pose an issue related to an above-mentioned concern about nurses being taken more seriously and gaining more power in health care because of the idea of women on the "mommy-track" falling behind in their careers (Buzzanell & Goldzwig, 1991). Every participant noted some type of unanticipated event within their career which shifted their plans in some way, highlighting the varied and ever-changing culture of the nursing profession as well as the importance of understanding career turning points in nursing. Bosley et al. (2009) state that analyzing turning points or meaningful events can help to explain changes in one's career trajectory. Although organizational research literature offers a range of findings on turning points, there is a lack of research which considers turning points within health care research. This is important to understand because nurse careers are often laden with several changes throughout their trajectory. Findings from the current study indicate that nurses do indeed recall specific moments which both led them to pursue careers in nursing in the first place and also to make

changes within their careers. They attribute these decisions to childhood experiences with nurses, impactful interactions with other nurses in nursing school and once they became a nurse, meaningful moments with patients, and others. Because of the perceptual nature of turning points, the constructionist perspective of this study is especially helpful in acknowledging the nurses' own interpretations of these events in their lives.

A final implication from this research question I want to emphasize is added understanding of expectations that new nurses have about their work. This study suggests that one major reason for the large amount of turnover in nursing is unmet expectations, as nurses enter the workforce only to realize the job is not how they envisioned it to be. Television shows which take place in health care settings often depict nursing jobs as not only narrow and unvaried but also as more glamorous at times than they are. Nurse participants, both from online posts and in interviews, frequently noted that television has got it wrong in terms of what nursing is really like. People considering becoming a nurse may think that they get to spend a lot of time one-on-one with patients, that there will be dramatic quandaries they get to solve daily, and they will be loved by everyone. However, according to nurses, the job is much less glamorous in every way. Instead, there is much more charting and paperwork; limited time and frequent and competing demands; unpleasant patients, families, and coworkers; and a great deal more stress than expected. Although participants also point out that it is rewarding in ways that they could not have imagined, the unmet expectations of what nursing work is really like can lead to job dissatisfaction and turnover. This contributes to Jablin's (1987) model of voluntary turnover by suggesting that unmet expectations are among antecedents which lead to members' affective responses and then turnover. However, it is not just unmet expectations themselves, but that nurses may also be complicit in creating and/or perpetuating these unmet expectations.

Television is not the only source of blame for these ideologies. Even though participants in this study openly discussed the difficulties of their jobs, this is not 'normal' talk when they are speaking with others. They may be less likely to describe the mundane details which take up most of their time and instead focus on the memorable moments and dramatic or glamorous aspects when talking about their job to others. After all, especially for those who do "dirty work," which nursing can be considered, "discourses also socially construct esteem-enhancing occupational identities, strong workgroup cultures, and positive social identities that provide affirmation for the work they do" (Lucas & Buzzanell, 2004, p. 277). Additionally, occupational narratives are responsible for building individual and organization identities and socializing new members (Lucas & Buzzanell, 2004) and also serve as a way to dignify certain jobs (Buzzanell & Lucas, 2013). Therefore, even though these stories of nursing may lead to unrealistic expectations of individuals choosing a nursing career, they serve positive purposes in building community and as shown in online discussion posts, a way for nurses to connect by discussing the humor in these dramatized narratives.

Relationships Among Socialization, Communication, and Occupational Identifications

This study highlights ways in which nurses influence each other and help to shape other nurses' identifications through communication. Nurse interview participants discussed how other nurses not only were influential before they became nurses, which led them later entering the profession, but also how other nurses made impressions on them in positive and negative ways which shaped the kind of nurse they became. Several participants talked about supportive nurses in their lives early on which led them to choose a nursing career and also encouraged them along the way to not give up. Influence related to vocational socialization has been established as making an impact even in childhood and adolescence (Jablin, 1985) and indicates that the

interactions nurses had as children with other nurses may have played an important role in how they view their work today. In other words, anticipatory socialization does play a role in how nurses identify with their work as well as their organizational choice (Jablin, 1985). There were other nurses whose positive behaviors showed participants how to be a good nurse, while others were so bad that they taught participants what *not* to do and even inspired them to be more conscious of their own behaviors. The influences that seasoned nurses have on newer nurses is particularly important. Stohl (1986) found that communication with higher-status, as opposed to lower-status, organizational members has a greater influence on new members in terms of socialization. The assimilation process—described by Waldeck and Myers as "a process through which organizational members influence the organizations in which they work, thus creating change within those organizations, and become affected by existing organizational practices and norms, thus changing as individuals" (2007, p. 325)—provides an answer to the above-mentioned problem of nurses perpetuating harmful ideologies of nursing work. Indeed, nurses are affected by existing norms as mentioned in the above quotation, but they also have the power to create change, as shown in participant examples in my study. Due to the nature of this study and the questions asked, there were more discussion about the influence that other nurses had on participants, but the influence participants as seasoned nurses have on newer members should also be acknowledged.

Connections Among Various Identification Targets

This study offers unique contributions in regard to social identity and self-categorization theories as well as theorizing about the construction of meaning. Social identity theory explains the role of the self within social group behavior (Tajfel & Turner, 1979) and how they compare themselves to others (Hogg, 2016), and self-categorization theory considers the individual within

that context (Turner, 1985) and how it creates a social identity (Hogg & Terry, 2000). These theories together explain how nurses communicate and situate themselves among others in their work. MacNeil (1997) suggests that turning points in a nurse's career could threaten their identities which can lead to stress, but there is a lack of research which explores this in detail and further, how socialization with other nurses constructs these identities.

This study answers Scott's (2007) call to expand identification research to further explore communication processes that matter in forming multiple identifications. Findings indicate that there are indeed stark differences in how nurses identify with their work team, organization, and the nursing profession and how these can at times align or conflict with their personal identifications. These findings challenge extant nursing research which conflates multiple occupational identification targets as one and the same. However, findings follow research (e.g., Ashforth & Johnson, 2001; Bullis & Bach, 1989a; Scott, 1997) which acknowledges the multiplicities of identification targets. For example, individuals can work in an organization whose mission may or may not be consistent with their overall profession or personal identity (Johnson et al., 2006). Interview and survey data align with extant research that organizational members often identify more strongly with their own work group than with their organization (Marique et al., 2014) as well as more strongly with their profession than their organization (Apker & Fox, 2002). Participants often stated feeling particularly attached to one target but not others; in many cases, they felt more connected to their immediate work teams because of a strong connection to those individual people, but less attached to their organization or profession because they felt small in comparison to the large number of other members within those targets. Other nurses had changed positions so frequently that they did not particularly feel attached to their work team but rather identified strongly with the profession because they can be a part of it

no matter what position they have within nursing. Further, some nurses' strength of identification changed toward a particular target due to turning points such as changes in management or increased involvement in a certain area of their work.

Findings for research question four indicate that team, organizational, and professional identification are all strongly correlated with each other, suggesting that each of these targets, while different, are all intertwined and work together to create workplace climate and culture. Participants identify most strongly with their team, followed by the nursing profession, and then the organization itself. Although these findings support some existing research on nursing identification (e.g., Apker & Fox, 2002), this study contributes uniquely because it considers all three targets as separate and distinguishable from each other. Some existing research conflates two or more occupational identification targets, which does not give us a clear understanding of how they work together or how they are different. Participants in my study gave various reasons why they identify more strongly with one target over others, which highlights the value of each individual target. For example, participants who most strongly identified with their work team note strong and established interpersonal relationships with coworkers and close connections to the work that they do on their specific team. Nurses who identify strongly with their organization state long tenure within their organization and close involvement with committees and various groups within the organization. Nurses who feel most strongly connected to the nursing profession as a whole find comfort in the fact that they are "always a nurse" no matter how their job positions or roles change. These are all very different reasons and some nurses place more importance on some of these factors than others, in part due to their experiences. For example, although most nurses list their work team as their closest identity, if a nurse does not feel close

with their work team or has not had the opportunity to build relationships with coworkers, they will prioritize other reasons for connecting to their work.

In addition to distinguishing between occupational targets, this study also makes a novel contribution by acknowledging the changing of identifications over time, which connects to turning points and memorable moments. We know that organizational members' identification can be expected to change over time (Bullis & Bach, 1989b), but my study recognizes specific reasons why this happens. For example, if a nurse gets the opportunity to become part of an organizational committee and learns the ins and outs of the organization and has a part in decision making, they may feel more closely connected to the organization than ever before. If an organization's mission changes or if a nurse's work team changes, they may feel less connected to their organization or work team and may even leave their job altogether, which would sever their ties with those targets. Therefore, identification is not static; it is in constant interaction with coworkers and events which impact a nurse's work.

Additionally, this study acknowledges the influence of personal identifications with occupational identification targets. Nurses often make decisions about whether they enjoy their work based on how it aligns with aspects of their personal identities. For example, nurse participants frequently noted a strong connection between personal values and their work as a nurse. Many of them shared stories about their desire to care for others or a personal calling that led them to choose their career path. Although identifying a career as a "calling" has been shown to lead to a number positive outcomes such as job satisfaction and career and organizational commitment (Duffy, Dik, & Steger, 2011), Berkelaar and Buzzanell (2015) note that talking about calling can also create issues of assumptions of necessity, invoked control, inequality, temporal continuity, and neoliberal economics. For example, "people with stronger senses of

calling lack insights necessary for career agency" which limits their control (Berkelaar & Buzzanell, 2015, p. 166). Additionally, Berkelaar and Buzzanell note that "historical invocations of calling often presume and reproduce dominant interests" and "such invocations often disavow the self-knowledge that could liberate disadvantaged groups from problematic invocations of calling that are perpetuated and legitimated by notions of order and office" which means "people often accept the status quo as their calling" (2015, p. 168). The two above points directly connect to issues which nurses have identified in their work: lack of power and control and the perpetuation of harmful, historical perspectives of nursing work. This again highlights my earlier point that some ways in which nurses communicate about their work can be helpful but also harmful in some ways.

Another way in which nurses align their work with their personal identities is by recalling moments on the job that either directly aligned with or conflicted with their personal values and it shaped their careers from that moment forward. For example, when one nurse, who had experienced multiple miscarriages, witnessed a baby dying at birth it impacted her so greatly that she decided to leave that unit of the hospital. Other nurses provide examples of messages from patients or coworkers which, although short, were impactful. It is common for organizational members to concisely recall moments or messages which shaped their work (Knapp, Stohl, & Reardon, 1981) and these messages play a critical role in the socialization and assimilation of members in an organization (Stohl, 1986). In fact, Stohl found that memorable messages serve socialization functions in ways such as providing information on norms and other aspects of an organization's culture and also highlights the importance of coworkers and others within the social network on organizational socialization. Additionally, socialization and assimilation, or similarly discussed as "membership negotiation" by Scott and Myers, connect to personal and

occupational identifications in that "identification is a medium of [membership negotiations] because it aids attempts to resolve tensions between individual needs for identity and collective organizational interests" and further, members' identification bolsters meaningful actions which help members to deal with stressors in their work while also enabling them to model acceptable behaviors for other members (2010, p. 95).

This study asks questions about career turning points, communication about careers, communicating online, and identifications in order to understand how each of them interplay with one another. Through this study, my goal was to show how all of these are related and influence each other. For example, organizational identification, as it has been broadly conceptualized in some studies as all identifications with one's work, is *not* just how one identifies with one's organization. We must consider one's work team, their organization, the profession as a whole, and personal identifications along with how an individual's experiences, including interactions that they have had with other nurses both before and while being a nurse as well as other turning points and memorable moments within their careers, shape these various identifications. The path is not linear, which is illustrated by how each nurse values different aspects of their identifications differently. We must think of nursing work (*and* I argue non-nursing work as well) as multi-faceted and complicated, considering the interplay of all of the above-mentioned aspects. Further, as more nurses turn to online discussion groups in search of socialization in forms of informational and emotional support, the existence of online spaces could completely change the culture of nursing.

Practical Implications

Health Care Organizations

In addition to the theoretical contributions above, this study provides several practical implications for nurses and leaders of health care organizations. Given the exceptionally high rate of turnover within the nursing profession, organizational leaders are driven to find ways to retain nurses (Halperin & Mashiach-Eizenberg, 2014). Current study findings regarding career decisions and identification help provide some insight on how management can recruit and retain nurses.

An important consideration for leaders in retaining employees lies in organizational identification. As noted previously, when an employee identifies strongly with their organization, they are more likely to effectively perform the tasks required of them as well as go above and beyond what is expected (Trybou et al., 2013). Strong organizational identification also includes employees agreeing with the organization's mission and making decisions which align with the organization's best interests (Apker & Fox, 2002). The problem which currently exists for organizations is that nurses identify more strongly with their immediate work teams and the nursing profession significantly more than they do with the organization. While having a strong connection to one's work team can be beneficial to the organization, even small changes within the work team can lead a nurse to leave the organization. Further, many nurses indicated that the strength of their work team is often not enough to retain them if they are unsatisfied with the organization or if another opportunity arises.

Findings regarding issues that nurses identified within their organizations and strengths that nurses discussed who strongly identified with their organization indicate that some ways in which organizations can retain nurses include listening to them, involving them in committees

and other activities, promoting an inclusive culture, aligning their goals with nurses' personal goals, fostering close work teams, and providing support. Nurses indicated that they struggle with being heard and respected by not only the larger community but also within their organizations and that policies within the organization are often made without considering their needs or feelings. Additionally, some nurses' identification with their organization increased after they joined committees because they become more involved and were able to have a say in changes and also see how things worked from the front lines. Findings also show that nurses left their organizations at times because the mission changed and no longer aligned with their person goals, or they felt too much of a conflict between their personal lives and what was expected from them at work. Further, although only part of the picture as indicated in the previous paragraph, a strong work team connection can influence nurses to stay in their current positions. Finally, nurses indicated having support from other nurses and managers can help them from burning out and leaving their job. Extant research support some of these suggestions as well. For example, Apker and Fox (2002) state that organizational messages to employees which connect organizational and personal values, missions, and goals can strengthen identification. Further, giving nurses more autonomy and support can strengthen nurses' organizational identification (Apker, Ford, & Fox, 2003).

Nurses

Findings from this study may also be helpful for nurses themselves in understanding ways in which other nurses have sought support, prevented burnout, and found happiness with their work. Given the high levels of stress and burnout which exist in nursing, it is likely that many nurses could benefit from learning what others have done to overcome these issues. One way in which some nurses have been able to reduce their stress and uncertainty and obtain

support is through seeking out other nurses in online spaces, which is discussed in more detail below. Additionally, nurses recommend seeking out a nurse mentor and also maintaining other friendships which can allow them to vent, share successes, and unwind. Other nurses have stressed the importance of practicing mindfulness and reminding themselves of the bigger picture. One nurse found it helpful to remind herself of "three good things" at the end of each shift. Finally, perhaps the most frequent advice that nurses gave when it came to finding happiness with the nursing profession was to find the right "fit"—nursing is an exceptionally broad profession with myriad opportunities and types of work available, and participants recommend trying a variety of hospital units and other positions in order to find what best suits one's needs. For example, several participants stated that they love their current jobs and have no intention of ever leaving once they left bedside nursing and became a nursing professor.

Additionally, nurses may be curious about how to change the harmful views of nursing that currently exist. Eisenberg (2008) notes that using new technology and ways of communicating effectively can break down the obstructive structures and lead to reconstructing meaning within the nursing profession. Indeed, nurse participants have insisted that they need to find ways to communicate more effectively. Participants urge other nurses to not only advocate for their patients but also for themselves. In other words, they can slowly change the culture by speaking up when an issue arises. Social identity theory and self-categorization theory help to explain how longstanding traditions and issues of power throughout nursing's history contribute to these same issues in the profession today. However, constructing and transforming nursing's image into the future will require mutual discussion and consensual change (Davis & Cox, 1994), highlighting the need for further communication in order to build cohesiveness within the profession.

Students and Those Considering Nursing

Further, this study helps nursing students and those considering nursing as a career option by offering practical advice and showing how others currently find information that may helpful to them. Findings which may be especially helpful to this group include how other nursing students, new nurses, and people considering a nursing career turn to online spaces for advice and guidance. The Internet offers communities of learning (Hutchinson & Watts, 2010) and nursing students do indeed use it. In this study, many students came to the r/nursing subreddit; however, they are guaranteed to also find a huge support system in the r/StudentNurse subreddit, which currently has over 28.5 thousand members.

Additionally, nurse participants offer many points of helpful advice for those considering a nursing career. Findings in this study suggest that young people often do not ask questions when considering a nursing career, perhaps because they do not know to do so or even know what to ask, but this information ahead of time may lessen the gap between expectations and reality of the job. Some common advice that seasoned nurses provide includes understanding that nursing is hard, especially when first starting out, and to not give up when this realization hits; to seek out mentors and support from other nurses as well as scheduling time for friends, family, and hobbies to maintain and healthy work-life balance and prevent burnout; take education seriously by trying many opportunities, but also enjoy the process; try to work several different units in order to gain skills and also find what is most enjoyable; and finally, to find the best fit for yourself by trying different experiences, thinking about what is most important personally, and considering options that may at first seem uninteresting.

Methodological Implications

Analyzing Online Spaces

This study also offers some methodological implications by answering a gap in the existing literature by analyzing data from online spaces as well as employing a mixed-methodological approach to explore research problems unique to these methods, such as understanding factors which motivate nurses to enter their profession, which has scantily been explored qualitatively or in online spaces. First, online spaces are useful places for nurses to go to obtain information, share stories with one another, and form supportive communities, among others (Brooks & Scott, 2006; Morris, 2005; Valaitis et al., 2011). However, we still know very little about how individuals communicate with each other online (Hooley et al., 2010). Some research has indicated that nurses go online for virtual mentoring, which is a helpful alternative in which they have access to many resources that the Internet provides (Knouse, 2001). As Knouse (2001) notes, virtual mentoring provides instrumental support in areas such as career guidance and psychosocial support such as discussing problems. Indeed, nurses do these things. They sought support on the internet for a variety of reasons, including to release stress through humor, sharing experiences, sharing information, venting, seeking advice on the job, and regarding schooling and considering nursing as a career. These nurses who came for support found it in the rich community of the r/nursing subreddit. The posts analyzed all had between approximately 30-500 comments so posters were able to get feedback and help from a variety of nurse sources from around the world. It also offered them an anonymous way of seeking this support if they were hesitant to confide in a coworker at work. Online spaces are also valuable for students because it makes available a variety of resources in a short amount of time (Venable, 2010). Findings showed that nursing students did take advantage of this, coming to r/nursing

with posts pertaining to venting or asking advice about nursing school, questions about patient procedures, and seeking information about certain degrees and nursing career paths.

Mixed-Methodologies

This study employs a mixed-methodological approach, which more fully addresses a research problem than just quantitative or qualitative methods by themselves (Creswell, 2014). Few research studies in either nursing career decisions or identification apply both methods concurrently to holistically understand these topics. For example, quantitative study findings from 440 nurses confirm that nurses identify most strongly with their proximal work team, followed by their profession, and then their organization; however, qualitative findings explain specifically *why* nurses identify with these targets as they do. Nurses tend to identify most strongly with their work teams for reasons such as having formed close interpersonal bonds with their proximal coworkers and members of the work team rely on and look up to them.

However, findings also highlight ways which lead nurses to detach from their work teams and/or feel more strongly attached to their organization or profession. This information is also helpful for health organizations looking to retain nurses and strengthen attachment, as mentioned above. Overall, not only did qualitative findings fulfill a need in extant nursing research to understand the connections between nurse communication, turning points and career decisions, and identification, but triangulation of data from online posts and questionnaires helped to strengthen the reliability of these results and provide a more holistic explanation of these research phenomena.

Limitations and Future Directions

This study is not without limitations. First, individual interview participants include only two males. Although only 9% of nurses in the United States are male (Certified Nurses Day, 2019), research (e.g., Evans & Frank, 2003) and some findings from online data suggest that issues such as bullying is experienced differently and maybe more frequently by male nurses, and it would be helpful to investigate more in-depth the experiences of men who pursue nursing and gendered differences if they exist. The second limitation is in regard to online data. This study analyzed data from one nursing subreddit group on reddit.com. Although findings align with extant research in non-nursing contexts, it would be helpful to understand differences in perhaps other nursing subreddits and even other nursing discussion forums. Additionally, other research questions in this study could be answered in part by online data. For example, collecting comments on specific posts that ask questions such as "What is it like being a nurse?" could provide a more holistic understanding of my second research question. A third limitation of this study pertains to survey respondents. Ninety percent of respondents indicated being Registered Nurses; this is somewhat representative of the population considering that RNs make up the largest group of nurses at over four million in the United States as compared to only 900 thousand LPNs (National Council of State Boards of Nursing, 2017) and 270 thousand NPs (American Association of Nurse Practitioners, 2019), for example. However, research (Johnson et al., 2006) indicates that professional with higher education levels may identify more strongly with their profession than organization, which suggests that there may be a difference between how nurses of different licensure identify with occupational targets. As it stands currently, I do not have enough data from participants other than RNs to be able to generalize statistical findings in this area.

Conclusion

This study sought to understand the interconnected influence of nurse communication, turning points and career decisions, and identification. Findings of this study helped to further understanding in the broad areas of how nurses (1) communicate with each other in online spaces, (2) describe what it means to be a nurse, (3) influence other nurses to make career decisions, and (4) identify with various occupational targets. This study also makes theoretical contributions to social identity and self-categorization theories and organizational identification and social constructionism; practical contributions for health organizations, nurses, and people considering becoming nurses; and methodological contributions for online data and mixed-methods research.

Notably, this study reveals the influence and interplay of career turning points (also thought of as memorable moments), career decisions and communication, socialization and assimilation, and occupational and personal identifications. Interestingly, all of these variables are apparent in nurse communication online. The intertwining nature of these variables are not often, but should be, considered in order to understand how nurses communicate with each other, think about how they are situated within their work, and make career decisions. Focusing on all of these variables together allowed me to connect to Jablin's and others' research where I otherwise would not have been able to make these connections. I believe this study has laid the groundwork to develop a continued research program that theorizes about why nurses enter and exit the profession. Furthermore, this study led me to believe that I should be considering other factors in this work, and I am looking forward to gathering more data in the future that would allow me to tease out the relationships between these variables in more detail. Additionally, while the context for this study is nurses specifically, what is happening between the variables

identified in this study could include other precarious workplace contexts, such as those in which people work on teams where there is a power disparity, some work for lower pay, or there are subgroups based on different kinds of identities. Findings from this study may translate into these contexts and encourage further study, as it seems that issues of power and disparity among nurses learned through this study are important.

Nursing is a rewarding and challenging profession wrought with stress, burnout, and turnover. Many leave the profession, but many others find happiness through a series of turning points and changes until they 'find their fit.' The nursing profession has a long journey ahead which will be filled with changes as they strive to enact policies which tend to patient and nurse needs, and work toward establishing a cohesive identity. Hopefully this current project and the work of others can contribute to the changes and needs of the nursing profession.

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APPENDIX A. INTERVIEW PROTOCOL FOR INDIVIDUAL NURSES

Introduction: "Hi, my name is Jen Ptacek and I'm a Ph.D. student in the Brian Lamb School of Communication at Purdue University. Thank you for agreeing to help me with my doctoral dissertation project. I am interested in understanding how nurses talk about their career decisions and how they identify with different aspects of their organization. Study findings will be used to contribute to the existing knowledge of nursing work and career turning points and trajectories, provide nurses and individuals considering nursing with information about career decisions, and may help health organizations in recruiting and keeping nurses from leaving their organizations.

This interview should take no longer than 60 minutes of your time. There are no right or wrong answers, and please answer as honestly as possible. Please change the names of any organizations or people that you reference so they cannot be identified. Your identity will also be kept private and a pseudonym will be assigned to you when reporting study findings in publications and conference papers.

Before we begin, I will review the informed consent document and answer any questions you have. Your verbal agreement of this document indicates that you choose to participate in this study and you agree to be recorded. If you do not wish to participate you may leave at this time. You may also stop participating in the interview at any time. Thank you again for your time."

<u>Topic 1: General information</u>

1. Can you please tell me a little about yourself?
    a. Can you please describe yourself in five words?
    b. What is your age?
    c. What is your nursing licensure?
    d. How long have you been a nurse?
    e. How long have you worked at your current organization?
    f. What are your duties in this current position?
2. Please tell me what it's like to be a nurse.
    a. Do you enjoy your job? Why or why not?
    b. What is the best part about your job?
    c. What is the worst part about your job?
    d. If you could start over, what career would you choose? (Nursing or something else?)

Topic 2: Targets of identification

3. Can you please describe your immediate work team?
    a. Who does the work team consist of? [How many members and their licensures/roles]
    b. How long have you been a member of this work team?
    c. How often do you interact with the members of your work team?
    d. Can you describe the dynamics of your work team? [Probe for details of how close the members are and if they provide each other with instrumental and/or emotional support].
4. Can you please describe your organization?
    a. What are the goals/mission of the organization as a whole?
    b. What types of people work for this organization? [ex: other nurses, doctors, administrative, etc.]
5. Can you please describe the nursing profession?
    a. Do you speak with other people about being a nurse? Who do you talk to? What do you say?
6. Since you have become a nurse, can you describe interactions that you have had with other nurses that shaped how you feel about your work team? [Probe for details: who was it and what did they say?]
    a. [Same questions but for organization]
    b. [Same questions but for profession]
7. Would you say that you are more strongly attached to your immediate work team, your organization, or the nursing profession? [Please rank the strength of attachment of each and explain why; two or more areas can be ranked the same]
8. Please rate your level of agreement with the following questions about your immediate work team: (5 choices ranging from strongly disagree to strongly agree)
    a. When someone criticizes my work team, it feels like a personal insult.
    b. I am very interested in what others think about my work team.
    c. When I talk about my work team, I usually say “we” rather than “they”.
    d. My work team’s successes are my successes.
    e. When someone praises my work team, it feels like a personal compliment.
    f. If a story in the media criticized my work team, I would feel embarrassed.
9. Please rate your level of agreement with the following questions about your organization: (5 choices ranging from strongly disagree to strongly agree)
    a. When someone criticizes my organization, it feels like a personal insult.
    b. I am very interested in what others think about my organization.
    c. When I talk about my organization, I usually say “we” rather than “they”.
    d. My organization’s successes are my successes.
    e. When someone praises my organization, it feels like a personal compliment.
    f. If a story in the media criticized my organization, I would feel embarrassed.
10. Please rate your level of agreement with the following questions about the nursing profession: (5 choices ranging from strongly disagree to strongly agree)
    a. When someone criticizes the nursing profession, it feels like a personal insult.
    b. I am very interested in what others think about the nursing profession.

c. When I talk about the nursing profession, I usually say "we" rather than "they".
d. Successes in the nursing profession are successes for me too.
e. When someone praises the nursing profession, it feels like a personal compliment.
f. If a story in the media criticized the nursing profession, I would feel embarrassed.

Topic 3: Career decisions

11. Why did you decide to become a nurse?
    a. When did you make this decision?
    b. Were there people that influenced you or played a role in guiding you to that decision? Who were they and what did they say?
    c. Did you ask anyone questions about nursing or becoming a nurse? Who did you ask and what did you ask them? What responses did you get?
    d. Can you recall any specific moments or turning points that particularly led you to decide to become a nurse? [Probe for details of these experiences. Discuss how they define "turning points" for clarification]
12. Why have you decided to continue being a nurse?
    a. Would you consider your job as a nurse your career?
    b. Do you think that you will always be a nurse? Why or why not?
    c. Do you think you would ever change careers? Why or why not?
13. What were your expectations when you decided to become a nurse? Were those expectations met?
    a. Do you have any disappointments about becoming a nurse? What are they?
    b. Is there anything that you wish you would have known before becoming a nurse?

Topic 4: Career trajectory

14. Now I'm going to ask you to recall the length of your career as a nurse and the time leading up to your decision to become a nurse. Please first draw out a timeline of this trajectory, including your nursing education and any jobs or position changes since then.
    a. Next, please fill in and discuss any turning points or memorable moments within this timeline.
        i. Was there anything that confirmed or influenced your decision to become a nurse? [Probe for details]
        ii. Was there anything that influenced you to change organizations or positions? [Probe for details]
        iii. Was there anything that made you want to leave your organization, work team, or nursing as a whole? [Probe for details]
15. Finally, is there anything else you would like to add?

"This concludes the interview. Thank you for sharing your time and experiences."

APPENDIX B. BRIEF DESCRIPTION OF RESEARCH STUDY FOR INTERVIEW PARTICIPANTS

"Hi, my name is Jen Ptacek and I am a Ph.D. student in the Brian Lamb School of Communication at Purdue University. For my doctoral dissertation project, I am interested in understanding how nurses talk about their career decisions and how they identify with different aspects of their organization. Study findings will be used to contribute to the existing knowledge of nursing work and career turning points and trajectories, provide nurses and individuals considering nursing with information about career decisions, and may help health organizations in recruiting and keeping nurses from leaving their organizations.

As part of my research study, I am conducting individual interviews with nurses, which are expected to last between 40-60 minutes. Participation is voluntary and if you choose to participate you will receive a $20 Amazon gift card. All of your personal information will be kept confidential and your answers will not be connected to your identity. If you are interested in participating or have any questions about this study, please contact me at jptacek@purdue.edu.

Thank you for your time and consideration."

APPENDIX C. RESEARCH PARTICIPANT CONSENT FORM FOR INTERVIEWS

Exploring the Salience of Occupational Identification Targets and Turning Points in Nurses' Career Trajectories

Principal Investigator: Stacey Connaughton, Ph.D.
Brian Lamb School of Communication
Purdue University

What is the purpose of this study?

This research study aims to understand how nurses talk about their career decisions and how they identify with different aspects of their organization. You are being asked to participate in this study because you are licensed as an Adult Nurse Practitioner (ANP), Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), Registered Nurse (RN), and/or Licensed Practical Nurse (LPN). We plan to enroll between 40-60 people in this study for individual interviews.

What will I do if I choose to be in this study?

You will be asked a number of questions in person or via Skype or phone call. Questions include (in chronological order): general information about yourself and your job; various "targets of identification" which include your immediate work team, organization, and profession; career decisions about becoming a nurse; and mapping out your career trajectory. These will help our research team answer questions about the following research questions:

1) How do nurses talk about what it means to be a nurse?
2) How have previous interactions with other nurses influenced nurses' perceptions of identification with various targets both before and after becoming a nurse?
3) What markers of various identification targets exist in nurse narratives about their work?

Although you will only be asked to participate in an interview, other data collected for this study consists of a questionnaire of nurses who participate in online discussion forums for nurses. If you participate in the interview in person, we can meet somewhere privately of your choosing such as a meeting room in a library, my university office, or your home; if you participate in the interview via Skype or phone, please choose somewhere private where you feel comfortable and are free of interruptions.

How long will I be in the study?

The total time commitment for your participation in this study is expected to be between 40-60 minutes during one session.

What are the possible risks or discomforts?

This research will ask you to reflect upon your experiences and attitudes toward your job and the nursing profession. You may feel uncomfortable thinking about your personal experiences or attitudes, and you may skip any questions that make you uncomfortable or stop the interview. As your responses will be kept confidential, there is no greater risk in participating in this study than you would encounter in daily life or during the performance of routine physical or psychological exams or tests. There is also a risk of breach of confidentiality, but steps have been taken to avoid such a breach. All digital data will be stored in Dropbox (an online system for document storage), which is password protected and only accessible by the co-PI, and all data will be de-identified and a code key will be kept separately in a locked file cabinet.

Are there any potential benefits?

There are no direct benefits to participating in this study. The data are meant to help us understand your perspectives and experiences. There are potential benefits of this study which include to contribute to the existing knowledge of nursing work and career turning points and trajectories, provide nurses and individuals considering nursing with information about career decisions, and may help health organizations in recruiting and keeping nurses from leaving their organizations.

Will I receive payment or other incentive?

You will receive a $20 Amazon gift card for participating in this study.

Will information about me and my participation be kept confidential?

Special steps will be taken to ensure that your participation is kept as private and confidential as possible. The name of participants will not be publicly shared in reports of research findings. Measures will be taken to secure the data and to maintain the confidentiality of participants.

Participants' names will not appear on the transcripts of the interviews or in any interview notes. Only the principal investigator (PI) and the co-investigator (co-PI) will know that a participant's name corresponds to a specific interview transcript. These transcripts will be stored in Dropbox (an online system for document storage), which is password protected and only accessible by the co-PI. All data will be de-identified and participants will be given pseudonyms in data reports. The code key will be kept separately in a lock file cabinet and will be destroyed at the close of the study.

The project's research records may be reviewed by departments at Purdue University responsible for regulatory and research oversight.

What are my rights if I take part in this study?

Your participation in this study is voluntary. You may choose not to participate or, if you agree to participate, you can withdraw your participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Who can I contact if I have questions about the study?

If you have questions, comments, or concerns about this research project, you can talk to one of the researchers. Please contact Dr. Stacey Connaughton, (765) 494-9107 or Jennifer Ptacek (first point of contact), (269) 271-1868.

If you have questions about your rights while taking part in the study or have concerns about the treatment of research participants, please call the Human Research Protection Program at (765) 494-5942, email (irb@purdue.edu) or write to:

Human Research Protection Program - Purdue University
Ernest C. Young Hall, Room 1032
155 S. Grant St.,
West Lafayette, IN 47907-2114

Documentation of Informed Consent

I have had the opportunity to read this consent form and have the research study explained. I have had the opportunity to ask questions about the research study, and my questions have been answered. I am prepared to participate in the research study described above. By agreeing to participate in this interview I am providing verbal consent to participate in this study.

APPENDIX D. QUESTIONNAIRE FOR NURSES IN ONLINE FORUMS

Introduction: "My name is Jen Ptacek and I'm a Ph.D. student in the Brian Lamb School of Communication at Purdue University. Thank you for agreeing to help me with my doctoral dissertation project. I am interested in understanding how nurses talk about their career decisions and how they identify with different aspects of their organization. Study findings will be used to contribute to the existing knowledge of nursing work and career turning points and trajectories, provide nurses and individuals considering nursing with information about career decisions, and may help health organizations in recruiting and keeping nurses from leaving their organizations.

This survey should take no longer than 20 minutes of your time. There are no right or wrong answers, and please answer as honestly and thoroughly as possible. Please change the names of any organizations or people that you reference so they cannot be identified. Your identity will also be kept private and a pseudonym will be assigned to you when reporting study findings.

By filling out this survey, you indicate that you choose to participate in this study. If you do not wish to participate you may exit the survey at any time. If you have any questions, please contact me at jptacek@purdue.edu. Thank you again for your time."

1. Please answer the following questions about yourself:
    a. Can you please list five words to describe yourself? (open-ended)
    b. What is your age? (choose from response options)
    c. What city and state do you live in? (open-ended)
    d. What is your nursing licensure? (please check all that apply)
        __ Licensed Practical Nurse (LPN)
        __ Registered Nurse (RN)
        __ Clinical Nurse Specialist (CNS)
        __ Nurse Practitioner (NP)
        __ Adult Nurse Practitioner (ANP)
        __ Other:
    e. How long have you been a nurse? (choose from response options)
    f. Approximately how many hours per week do you work? (choose from response options)
    g. What type of organization do you work at? (please check an option)
        __ Hospital

__ Nursing Home

__ School

__ Other:

h. How long have you worked at your current organization? (choose from response options)
i. What are your duties in this current position? (open-ended)

2. Which forum(s) listed below do you participate in? (please check all that apply)
__ groups.able2know.org/nurse-forum/

__ justusnurses.com

__ nursingvoices.com

__ reddit.com

__ ultimatenurse.com/forum/

__Other:

3. What is your username within these forums? (open-ended)
4. Why do you participate in these forums? (open-ended)
5. Do you ask questions on the forums? (choose from yes or no)
    a. If yes, what kinds of questions do you ask? (open-ended)
    b. If yes, what kinds of advice or answers have other forum participants given you? (open-ended)
6. Do you answer questions on the forums? (choose from yes or no)
    a. If yes, what kinds of questions have you responded to? (please list as many as you can remember)
    b. If yes, what kinds of advice or answer have you given to other forum participants? (open-ended)
7. Do you talk to other nurses about your job? (yes or no)
    a. If yes, what do you talk about? (open-ended)
8. Do you talk to anyone else about being a nurse? (yes or no)
    a. If yes, who do you talk to? (choose among options, including an "other" open-ended option)
    b. If yes, what do you talk about? (open-ended)
9. When you were considering becoming a nurse, who did you talk to? (choose among options, including an "other" open-ended option)
__ Friends who were nurses

__ Family who were nurses

__ Coworkers who were nurses

__ Friends who were not nurses

__ Family who were not nurses

__ Coworkers who were not nurses

__Other:

10. When you were considering becoming a nurse, what kinds of questions did you ask others? (open-ended)
11. Would you recommend nursing as a profession to other people? (yes or no)
    a. If yes, why? (open-ended)
    b. If no, why? (open-ended)
12. Please rate your level of agreement with the following questions about your immediate work team: (5 choices ranging from strongly disagree to strongly agree)
    a. When someone criticizes my work team, it feels like a personal insult.
    b. I am very interested in what others think about my work team.
    c. When I talk about my work team, I usually say "we" rather than "they".
    d. My work team's successes are my successes.
    e. When someone praises my work team, it feels like a personal compliment.
    f. If a story in the media criticized my work team, I would feel embarrassed.
13. Please rate your level of agreement with the following questions about your organization: (5 choices ranging from strongly disagree to strongly agree)
    a. When someone criticizes my organization, it feels like a personal insult.
    b. I am very interested in what others think about my organization.
    c. When I talk about my organization, I usually say "we" rather than "they".
    d. My work team's successes are my successes.
    e. When someone praises my organization, it feels like a personal compliment.
    f. If a story in the media criticized my organization, I would feel embarrassed.
14. Please rate your level of agreement with the following questions about the nursing profession: (5 choices ranging from strongly disagree to strongly agree)
    a. When someone criticizes the nursing profession, it feels like a personal insult.
    b. I am very interested in what others think about the nursing profession.
    c. When I talk about the nursing profession, I usually say "we" rather than "they".
    d. My work team's successes are my successes,
    e. When someone praises the nursing profession, it feels like a personal compliment.
    f. If a story in the media criticized the nursing profession, I would feel embarrassed.

This concludes the survey. Thank you for your participation! If you would like to be entered into a drawing to win a $20 Amazon gift card, please include your email address below.

APPENDIX E. SURVEY INVITATION FOR NURSES IN ONLINE FORUMS

"My name is Jen Ptacek and I am a Ph.D. student in the Brian Lamb School of Communication at Purdue University in the United States. For my doctoral dissertation project, I am interested in understanding how nurses talk about their career decisions and how they identify with different aspects of their organization. Study findings will be used to contribute to the existing knowledge of nursing work and career turning points and trajectories, provide nurses and individuals considering nursing with information about career decisions, and may help health organizations in recruiting and keeping nurses from leaving their organizations.

As part of my research study, I have created this survey for nurses who participate in online discussion forums. If you are an Adult Nurse Practitioner (ANP), Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), Registered Nurse (RN), or Licensed Practical Nurse (LPN), I invite you to participate in my survey. This survey should take no longer than 20 minutes of your time and your identity will be kept confidential. Participation is voluntary and if you choose to participate, you can enter to win one of five $20 Amazon gift cards. If you have any questions, please contact me at jptacek@purdue.edu.

Please click on the link below to take the survey. Thank you for your time and consideration."

APPENDIX F. RESEARCH PARTICIPANT CONSENT FORM FOR QUESTIONNAIRES

Exploring the Salience of Occupational Identification Targets and Turning Points in Nurses' Career Trajectories

Principal Investigator: Stacey Connaughton, Ph.D.

Brian Lamb School of Communication

Purdue University

What is the purpose of this study?

This research study aims to understand how nurses talk about their career decisions and how they identify with different aspects of their organization. You are being asked to participate in this study because you are licensed as an Adult Nurse Practitioner (ANP), Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), Registered Nurse (RN), and/or Licensed Practical Nurse (LPN). We plan to enroll between 100-1000 people in this study for questionnaires.

What will I do if I choose to be in this study?

You will be asked a number of questions in a Qualtrics survey. Questions include (in chronological order): general information about yourself and your job; participation behaviors in online discussion forums for nurses; career decisions; and how you feel about various "targets of identification" which include your immediate work team, organization, and profession. These will help our research team answer questions about the following research questions:

1) How do nurses talk about what it means to be a nurse?
2) How have previous interactions with other nurses influenced nurses' perceptions of identification with various targets both before and after becoming a nurse?
3) What markers of various identification targets exist in nurse narratives about their work?

Although you will only be asked to participate in a survey, other data collected for this study consists of individual interviews with nurses. While participating in this survey, please choose somewhere private where you feel comfortable and are free of interruptions.

How long will I be in the study?

The total time commitment for your participation in this study is expected to be approximately 20 minutes during one session.

What are the possible risks or discomforts?

This research will ask you to reflect upon your experiences and attitudes toward your job and the nursing profession. You may feel uncomfortable thinking about your personal experiences or attitudes, and you may skip any questions that make you uncomfortable or stop the interview. As your responses will be kept confidential, there is no greater risk in participating in this study than you would encounter in daily life or during the performance of routine physical or psychological exams or tests. There is also a risk of breach of confidentiality, but steps have been taken to avoid such a breach. All survey data will be collected through Qualtrics, which is password protected and only accessible by the co-PI, and data will be saved to an Excel file and will be stored in Dropbox (an online system for document storage), which is password protected and only accessible by the co-PI. Your name will not be collected in this survey and if you enter your email for the drawing to win a gift card, your email address will not be connected to your survey answers.

Are there any potential benefits?

There are no direct benefits to participating in this study. The data are meant to help us understand your perspectives and experiences. There are potential benefits of this study which include to contribute to the existing knowledge of nursing work and career turning points and trajectories, provide nurses and individuals considering nursing with information about career decisions, and may help health organizations in recruiting and keeping nurses from leaving their organizations.

Will I receive payment or other incentive?

You will be given the option to enter a drawing to receive a $20 Amazon gift card for participating in this study. There will be a total of five gift cards randomly given to all who enter, and chances of winning are between 1/20 to 1/200.

Will information about me and my participation be kept confidential?

Special steps will be taken to ensure that your participation is kept as private and confidential as possible. Your name will not be collected at any point during this study and your username in the discussion forums will not be publicly shared in reports of research findings. Measures will be taken to secure the data and to maintain the confidentiality of participants. Only the principal investigator (PI) and the co-investigator (co-PI) will know that a participant's forum username corresponds to a specific survey answer. These survey results will be stored in Dropbox (an online system for document storage), which is password protected and only accessible by the co-PI. All data will be de-identified and participants will be given pseudonyms in data reports.

The project's research records may be reviewed by departments at Purdue University responsible for regulatory and research oversight.

What are my rights if I take part in this study?

Your participation in this study is voluntary. You may choose not to participate or, if you agree to participate, you can withdraw your participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Who can I contact if I have questions about the study?

If you have questions, comments, or concerns about this research project, you can talk to one of the researchers. Please contact Dr. Stacey Connaughton, (765) 494-9107 or Jennifer Ptacek (first point of contact), (269) 271-1868.

If you have questions about your rights while taking part in the study or have concerns about the treatment of research participants, please call the Human Research Protection Program at (765) 494-5942, email (irb@purdue.edu) or write to:

Human Research Protection Program - Purdue University
Ernest C. Young Hall, Room 1032
155 S. Grant St.,
West Lafayette, IN 47907-2114

Documentation of Informed Consent

I have had the opportunity to read this consent form and have the research study explained. I have had the opportunity to ask questions about the research study, and my questions have been answered. I am prepared to participate in the research study described above. By taking this questionnaire I am providing verbal consent to participate in this study.

VITA

Jennifer K. Ptacek
Curriculum Vitae

Brian Lamb School of Communication
Beering Hall, Purdue University
100 N. University St.
West Lafayette, IN 47907
Email: jptacek@purdue.edu

ACADEMIC PREPARATION

Ph.D., Communication, August 2019
Purdue University, West Lafayette, IN
Specialization: Organizational Communication and Health Communication
Committee: Stacey Connaughton, Ph.D. (Advisor); Patrice Buzzanell, Ph.D.; Natalie Lambert, Ph.D.; Kathy Abrahamson, Ph.D.
Dissertation: *Exploring the Salience of Occupational Identification Targets and Turning Points in Nurses' Career Trajectories*

M.A., Communication, December 2014
Western Michigan University, Kalamazoo, MI
Specialization: Organizational Communication
Committee: Julie Apker, Ph.D. (Advisor); Stacey Wieland, Ph.D.; Leah Omilion-Hodges, Ph.D.
Thesis: *Exploring the Communication Dynamics of Peer Friendships in Nursing: A Qualitative Study of Nurse Stress and Coping Communication*

B.A., Communication, April 2009
Western Michigan University, Kalamazoo, MI
Major: Communication; Minor: English

TEACHING EXPERIENCE

Assistant Director, Fundamentals of Speech Communication (COM 114)
Brian Lamb School of Communication, Fall 2018 – present

Graduate Assistant, Online MS in Communication Program
Brian Lamb School of Communication, Summer 2018 – present

Courses Taught at Purdue University, Brian Lamb School of Communication (West Lafayette, IN)
COM 318 – Principles of Persuasion
Instructor of Record, Distance Learning Section, Spring 2019
Teaching Assistant for Dr. William Collins, Fall 2017, Spring 2018

COM 304 – Quantitative Methods for Communication Research
Teaching Assistant for Dr. Maria Venetis, Spring 2018; Dr. Evan Perrault, Fall 2018

COM 217 – Science Writing and Presentation
Instructor of Record, Summer 2018

COM 314 – Advanced Presentational Speaking
Instructor of Record, Summer 2017

COM 204 – Critical Perspectives in Communication
Teaching Assistant for Dr. Josh Boyd, Fall 2016, Spring 2017

COM 324 – Organizational Communication
Instructor of Record, Fall 2016

COM 114 – Fundamentals of Speech Communication
Instructor of Record, Fall 2015, Spring 2016, Summer 2016

Courses Taught at Western Michigan University, School of Communication (Kalamazoo, MI)

COM 1700 – Interpersonal Communication
Instructor of Record, Fall 2014 (1 class), Spring 2015 (3 classes)

COM 3070 – Freedom of Expression
Teaching Assistant for Dr. Richard Gershon, Fall 2014

COM 6800 – Graduate Seminar in Micro-Organizational Communication
Guest Lecturer, "Workplace Friendships" Fall 2014

COM 1040 – Public Speaking
Co-Instructor for Dr. Leah Omilion-Hodges, Summer 2014

COM 3050 – The Practice of Leadership
Teaching Assistant for Dr. Peter Northouse, Fall 2008

Courses Taught at Kalamazoo Valley Community College, Department of Communication (Kalamazoo, MI)

COM 113 – Interpersonal Communication
Instructor of Record, Spring 2015 (2 classes)

Student Ratings of Teaching as Instructor of Record at Purdue University

Core items for School of Communication: numbers after course number indicate [number of students enrolled/number of students completing evaluation forms]. Scores were measured on a 5.0 scale.

1. My instructor shows respect for diverse groups of people.
2. This course has been challenging.

3. This course has been well organized.
4. This course has provided a meaningful learning experience.
5. My instructor displayed genuine interest in the topics covered in this class.
6. My instructor has been well prepared for class each day.
7. My instructor has provided useful feedback throughout the semester.
8. My instructor has treated all students in class with respect.
9. My instructor has created an atmosphere that promotes learning.
10. Overall, I would rate this course as:
11. Overall, I would rate this instructor as:

Q#:	**#1**	**#2**	**#3**	**#4**	**#5**	**#6**	**#7**	**#8**	**#9**	**#10**	**#11**
COM 114/F15 [19/24]	5.0	3.9	4.2	4.0	4.9	4.9	4.8	4.9	4.8	3.9	4.9
COM 114/SP16 [21/25]	4.9	3.9	4.2	4.2	4.9	4.8	4.9	4.9	4.9	4.0	4.9
COM 114/SU16 [16/18]	4.9	4.0	4.5	4.5	4.9	4.9	4.9	4.9	4.9	4.3	4.9
COM 324/F16	4.9	4.0	4.2	4.2	4.9	4.9	4.5	4.9	4.9	4.2	4.7
COM 314/SU17	5.0	3.8	4.8	4.8	5.0	5.0	5.0	5.0	5.0	5.0	5.0
COM 217/SU18 [7/14]	4.9	4.3	4.9	4.6	4.9	4.9	4.6	4.8	5.0	4.9	5.0

PEDAGOGICAL ACTIVITIES

2018 Attended four Foundations of College Teaching Series workshops
Center for Instructional Excellence, Purdue University

2018 Attended Question, Persuade, and Refer (QPR) Suicide Prevention Gatekeeper training
Office of the Dean of Students, Purdue University

2018 Attended Safe Zone training (to provide support for the lesbian, gay, bisexual, transgender, queer, and questioning community)
LGBTQ Center, Purdue University

2018 Conducted a classroom climate teaching workshop
Brian Lamb School of Communication Instructional Mentorship Program, Purdue University

2018 Presented a G.I.F.T.S. (Great Ideas for Teaching Students): Mediated-reflexivity in the flipped classroom
International Communication Association conference

2015-2018 Attended G.I.F.T.S. (Great Ideas for Teaching Students) panel
National Communication Association conference

2017 Presented a G.I.F.T.S. (Great Ideas for Teaching Students): Teaching organizational identification through photography and student experiences
Central States Communication Association conference

2015-2016 Attended G.I.F.T.S. (Great Ideas for Teaching Students) panel
Central States Communication Association conference

2016 Attended a diversity training workshop
Center for Instructional Excellence, Purdue University

2015 Attended semester-long instructional training for COM 114
Brian Lamb School of Communication, Purdue University

SCHOLARLY ACTIVITY AND ACCOMPLISHMENTS

Academic Publications

Ptacek, J. K., Kamal, D., Rawat, M., Linabary, J. R., & Connaughton, S. L. (forthcoming). Doing locally led peacebuilding: An examination of the relationally attentive approach to conducting engaged scholarship in Liberia. In P. Kellett, S. Connaughton, & G. Cheney (Eds.). *Conflict transformation and peacebuilding through engaged scholarship and practice*. Peter Lang Publishing.

Connaughton, S. L., & **Ptacek, J.** (2019). Doing engaged scholarship: Inclusion theory meets practice in the context of a peacebuilding initiative in West Africa. In M. Doerfel & J. L. Gibbs (Eds.). *Building Inclusiveness in Organizations, Institutions, and Communities: Communication Theory Perspectives*. New York: Routledge.

Ptacek, J. K., Dolick, K. N., & Mattson, M. (2018). Advocacy groups as agents for change in health and risk messaging. In *Encyclopedia of Health and Risk Message Design and Processing* (pp. 70-90). New York: Oxford University Press.

Ptacek, J. K. (2017). Managing identity gap: Exploring experiences of first generation college students. Abstract published in *Michigan Academician*.

Apker, J., **Ptacek, J.,** Beach, C., & Wears, R. (2016). Exploring role dialectics in inter-service admission handoffs: A qualitative analysis of physician communication. *Journal of Applied Communication Research*.

Omilion-Hodges, L. M., **Ptacek, J. K.**, & Zerilli, D. (2016). A comprehensive review and communication research agenda of the contextualized workgroup: The evolution and future of leader-member exchange, coworker exchange, and team-member exchange. *Communication Yearbook*, *40*, 343-377.

Ptacek, J. K. (2016). Constructing meaning through metaphors: Using objects to describe close work friendships. Abstract published in *Michigan Academician*.

Ptacek, J. K. (2015). Exploring the communication dynamics of peer friendships in nursing: A critical literature review of nurse stress and coping communication. Abstract published in *Michigan Academician*.

Apker, J., Beach, C., O'Leary, K., **Ptacek, J.**, Cheung, D., & Wears, R. (2014). Handoff communication and electronic health records: Exploring transitions in care between emergency physicians and internal medicine/hospitalist physicians. *Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare*. Los Angeles: Sage.

<u>Practitioner Publications</u>

Linabary, J. L., Connaughton, S. L., Yeanay, G., & **Ptacek, J.** (2018, July). Playing with the 'enemy': Football offers peace chance in Liberia. *Peace News*. Retrieved from https://www.peacenews.com/single-post/2018/07/04/Playing-with-the-%25E2%2580%2598enemy%25E2%2580%2599-Football-as-an-opportunity-for-peace-in-Liberia

Linabary, J., Connaughton, S., **Ptacek, J.**, Rawat, M. & Yeanay, G. (2018, March). Local citizens play key role in promoting peaceful elections in Liberia. *Diplomatic Courier*. Retrieved from https://www.diplomaticourier.com/local-citizens-play-key-role-in-promoting-peaceful-elections-in-liberia/

<u>Manuscripts Under Review or in Preparation</u>

Ptacek, J., & Apker, J. (revise and resubmit). Getting a little help from friends: A case study of supportive communication between close work friends in nursing. Revise and resubmit at *Health Communication*.

Omilion-Hodges, L. M., & **Ptacek, J. K.** (revise and resubmit). Communicative complexity and effort: Relating personal factors to young adults' ability to develop fruitful working leader-member relationships. Submitted to *International Journal of Business Communication*.

Reimer, T., Connaughton, S., Roland, C., **Ptacek, J.**, & Krishna, A. (under review). Predictors of armed intergroup-conflicts: A systematic overview of risk factors. Submitted to *Annals of the International Communication Association*.

Linabary, J. R., Connaughton, S. L., Krishna, A., Vibber, K. S., **Ptacek, J.**, Pauly, J. A., & Anaele, A. 'Soldier on': Navigating gender, vulnerability, and emotions in the field. Manuscript in preparation.

Ptacek, J. K., Omilion-Hodges, L. M., & Zerilli, D. Sticking together: A qualitative analysis of strategic relationships in the workplace. Manuscript in preparation.

Omilion-Hodges, L. M., Zerilli, D., & **Ptacek, J. K.** "Who has your back and who will throw you to the wolves?" A qualitative analysis of support and antagonism in workplace relationships. Manuscript in preparation.

Conference Papers, Posters and Presentations

Ptacek, J., & Connaughton, S. (under review). Addressing the intersections of health, organizing, and peacebuilding: A case study of peacebuilding in Liberia. Submitted to the Peace and Conflict Communication Division at the 2019 National Communication Association 105th Annual Convention, Baltimore, MD.

Collins, W., Hall, J., **Ptacek, J.**, Welch, J., Miller, K., Rawat, M., Kendall, M., & Knighton, D. (under review). Assessing satisfaction, learning, and professional outcomes in online graduate communication education: Two studies from a large online professional master's program. Submitted to the Communication Assessment Division at the 2019 National Communication Association 105th Annual Convention, Baltimore, MD.

Omilion-Hodges, L. M., & **Ptacek, J. K.** (2019). Communicative complexity and effort: Relating personal factors to young adults' ability to develop fruitful working leader-member relationships. Paper to be presented at the 2019 69th Annual International Communication Association Conference, Washington, DC.

Ptacek, J. K. (2018). Nurse turning points and career trajectories: What we know and what lies ahead. Paper presented at the Student Section at the 2018 National Communication Association 104th Annual Convention, Salt Lake City, UT.

Ptacek, J. K. (2018). Investigating nurse identification and career communication in online spaces through computational analyses. Extended abstract presented at the Research in Progress Roundtables unit at the 2018 National Communication Association 104th Annual Convention, Salt Lake City, UT.

Ptacek, J. K., & Kamal, D. (2018). Conducting a social network analysis of the role of electronic support groups on under-recognized health conditions. Extended abstract presented at the Research in Progress Roundtables unit at the 2018 National Communication Association 104th Annual Convention, Salt Lake City, UT.

Ptacek, J., Martinez, E., & Buzzanell, P. (2018). GIFTS: Mediated-Reflexivity in the Flipped Classroom. Great Ideas for Teaching Students proposal presented at the 68th Annual International Communication Conference, Prague, Czech Republic.

Reimer, T., Connaughton, S., Roland, C., **Ptacek, J.**, & Krishna, A. (2017). Predictors of armed intergroup-conflicts: A systematic overview of risk factors. Paper presented at the 2017 National Communication Association 103rd Annual Convention, Dallas, TX. **(Top Paper Award – Peace and Conflict Communication Division)**

Ptacek, J. (2017). Purdue Peace Project in Liberia: Promoting Peace through Performing Arts. Presentation at the West Lafayette Public Library Lecture Series.

Connaughton, S. L., Yakova, L., Linabary, J., Pauly, J., **Ptacek, J.**, Stumberger, N., Kamal, D., Rawat, M., & Timmons, E. (2017). The Purdue Peace Project: Promoting peace through locally led initiatives in West Africa. Poster presented at the Purdue in Africa Event, Purdue University.

Ptacek, J. K., & Kamal, D. (2017). Analyzing the social networks of electronic support groups for contested illnesses. Abstract presented at the 15th Annual International Communication, Medicine, and Ethics Conference, Indianapolis, IN.

Ptacek, J. K., & Kamal, D. (2017). Effectiveness is in the eye of the beholder: A qualitative approach to understanding differences in perceptions of fitspiration. Abstract presented at the 13th International Congress of Qualitative Inquiry, University of Illinois at Urbana-Champaign.

Kamal, D., & **Ptacek, J. K.** (2017). Perceptions of fitspiration messages: A new approach to physical activity promotion. Abstract presented at the 4th Biennial D.C. Health Communication Conference, Fairfax, VA.

Martinez, E., **Ptacek, J. K.** (2017). Teaching organizational identification through photography and student experiences. G.I.F.T. presented at the 2017 Central States Communication Association Conference, Minneapolis, MN.

Ptacek, J. K. (2017). Applying a social identity theoretical framework to explore the role of socialization in graduate student identification. Abstract presented at the 2017 Michigan

Academy of Science Arts and Letters Conference, Kalamazoo, MI.

Linabary, J. R., Connaughton, S. L., **Ptacek, J.**, Krishna, A., Pauly, J., Vibber, K., & Anaele, A. (2016). 'Soldier on': Navigating gender, vulnerability, and emotions in the field. Paper presented at the 2016 National Communication Association 102nd Annual Convention, Philadelphia, PA.

Connaughton, S. L., Pauly, J., Linabary, J., Yakova, L., Krishna, A., Stumberger, N., & **Ptacek, J.** (2016). Organizing to identify and identifying to organize: The unanticipated endurance of identifications in a voluntary social collective. Paper presented at the 2016 National Communication Association 102nd Annual Convention, Philadelphia, PA.

Kamal, D., & **Ptacek, J. K.** (2016). Source of inspiration or negative body perception?: An examination of fitspo content. Extended abstract presented at the Research in Progress Roundtables unit at the 2016 National Communication Association 102nd Annual Convention, Philadelphia, PA.

Potts, L., & **Ptacek, J. K.** (2016). Feeling in the field: The impact of culture on the experience and management of researcher emotion. Extended abstract presented at the Research in Progress Roundtables unit at the 2016 National Communication Association 102nd Annual Convention, Philadelphia, PA.

Dolick, K., & **Ptacek, J. K.**, & Mattson, M. (2016). Understanding energy drink consumer attitudes and behaviors: Initiating policy change through a health advocacy campaign. Extended abstract presented at the Research in Progress Roundtables unit at the 2016 National Communication Association 102nd Annual Convention, Philadelphia, PA.

Ptacek, J. K. (2016). Exploring gender in fieldwork from a feminist perspective. Paper presented at the annual conference of the Organization for the Study of Communication, Language, and Gender, Chicago, IL.

Ptacek, J. K., & Apker, J. (2016). "She holds me together like duct tape": Exploring close nurse friendship through metaphors. Paper presented at the 2016 Central States Communication Association Conference, Grand Rapids, MI.

Ptacek, J. K. (2016). Managing identity gap: Exploring experiences of first generation college students. Paper presented at the 2016 Michigan Academy of Science Arts and Letters Conference, University Center, MI.

Ptacek, J. K., & Dolick, K. (2016). Applying the HCAM to policy change for energy drinks. Poster presented at the 2016 Health and Disease: Science, Technology, Culture and Policy Research Poster Session, West Lafayette, IN.

Kamal, D., & **Ptacek, J. K.** (2016). Assessing message effectiveness of female fitness personalities in social media: A content analysis. Paper presented at the 2016 Communication Graduate Student Organization Conference, West Lafayette, IN.

Dolick, K., **Ptacek, J. K.**, Wang, K., & Smith, S. (2016). Health advocacy campaign for policy change on energy drink labeling: A research proposal. Paper presented at the 2016 Communication Graduate Student Organization Conference, West Lafayette, IN.

Apker, J., **Ptacek, J.**, Beach, C., & Wears, R. (2015). Exploring physician role dialectics in inter-service handoff communication: Practicing beside each other. Paper presented at the 2015 National Communication Association Annual Meeting, Las Vegas.

Omilion-Hodges, L., Zerilli, D., & **Ptacek, J.** (2015). Qualitative analysis of support and antagonism in workplace relationships. Paper presented at the 2015 National Communication Association Annual Meeting, Las Vegas.

Ptacek, J., & Apker, J. (2015). Exploring close nurse friendship communication: An analysis of artifacts and storytelling. Paper presented at the 2015 International Conference on Communication in Healthcare, New Orleans.

Ptacek, J. K., & Apker, J. A. (2015). Getting by with a little help from friends: Supportive communication behaviors between close work friends in nursing. Paper presented at the 2015 Central States Communication Association Conference, Madison, WI.

Omilion-Hodges, L. M., **Ptacek, J.**, & Zerilli, D. (2015). A comprehensive review and communication research agenda of the contextualized workgroup: The evolution and future of LMX, CWX, and TMX. Paper presented at the 2015 Central States Communication Association Conference, Madison, WI.

Ptacek, J. K. (2015). Constructing meaning through metaphors: Using objects to describe close work friendships. Paper presented at the 2015 Michigan Academy of Science Arts and Letters Conference, Rochester, MI.

Ptacek, J. K., & Apker, J. (2014). Coping with stress through friends: A case study of nurses' close work friendship and supportive communication. Paper presented during roundtables in research in progress at the 2014 National Communication Association Conference, Chicago, IL.

Ptacek, J. K. (2014). Using humor with nurse friends to cope with workplace stress. Poster presented at the 2014 Organization Communication Mini Conference, West Lafayette, IN.

Apker, J., Beach, C., O'Leary, K., **Ptacek, J.**, Cheung, D., & Wears, R. (2014). Handoff communication and electronic health records: Exploring transitions in care between emergency physicians and internal medicine/hospitalist physicians. Paper presented at the 2014 International Symposium of Human Factors and Ergonomics in Healthcare, Chicago, IL.

Ptacek, J. K. (2014). Exploring workplace friendship through social exchange theory to reduce stress. Poster presented at the 2014 Research and Creative Activities Poster Day, Kalamazoo, MI.

Ptacek, J. K. (2014). The changing climate of workplace friendship: A critical literature review of friendship communication. Paper presented at the 2014 WMU Graduate Humanities Conference, Kalamazoo, MI.

Ptacek, J. K. (2014). Exploring the communication dynamics of peer friendships in nursing: A critical literature review of nurse stress and coping communication. Paper presented at the 2014 Michigan Academy of Science Arts and Letters Conference, Rochester, MI.

Collaborative Research Experience

Co-Investigator: Collected and analyzed data for a quantitative study and manuscript in progress on student expectations of future leadership with Dr. Leah Omilion-Hodges, Fall 2018-current

Co-Investigator: Researcher on a project investigating how students find and use information in their school work. Assessing the effectiveness of various instructional materials through coding instructional presentations of students enrolled in presentational speaking courses at Purdue University. Project led by Dr. Jennifer Hall in the Brian Lamb School of Communication and Dr. Clarence Maybee of Purdue Libraries, Fall 2018-current

Research Assistant: Collected data and conducted social network analyses on communication as a predictor of political violence in African countries with Dr. Torsten Reimer, Spring 2018-current

Research Assistant: Collected and analyzed data pertaining to online narratives about breast cancer with Dr. Natalie Lambert and Dr. Evan Perrault, Spring 2017-current

Research Assistant: Researcher on projects in Liberia as part of a political violence prevention initiative with locally driven projects in West Africa. Contributed to several manuscripts in progress and publications in edited book chapters, practitioner pieces, and academic journals. Traveled to multiple counties in Liberia to conduct interviews and observations during a peaceful elections initiative on behalf of the Purdue Peace Project led by Dr. Stacey Connaughton, Spring 2016-current

Research Assistant: Conducted focus group interviews with six- to eight-year old children for a study contributing to a submission to the America's Best Communities national competition with Dr. Steven Wilson and Dr. Patrice Buzzanell, Fall 2015

Co-Investigator: Conducted interviews and research for a qualitative study and forthcoming publication on the exchange relationships between employees and managers with Dr. Leah Omilion-Hodges, Summer 2014-Summer 2015

Co-Investigator: Conducted a literature review for a theoretical publication integrating leader-member exchange (LMX), coworker exchange (CWX), and team-member exchange (TMX) with Dr. Leah Omilion-Hodges, Summer 2014-Spring 2015

Co-Investigator: Conducted interviews and research for a qualitative study and wrote a publication on healthcare handoff communication with Dr. Julie Apker, Summer 2014-Spring 2015

Research Assistant: Contributed to an NSF Science of Organizations grant proposal, including preparation, writing, crafting arguments and a concepts study. Conducted participant interviews, data analysis, and literature reviews on reciprocity across disciplines with Dr. Leah Omilion-Hodges and Dr. Brian Gogan, Summer 2013-Winter 2014

Research Assistant: Conducted participant interviews and data analysis and contributed to a publication on healthcare handoff communication with Dr. Julie Apker, Fall 2013-Fall 2014

Research Assistant: Conducted data analysis on nurse stress coping communication with Dr. Leah Omilion-Hodges and Dr. Julie Apker, Spring 2013

HONORS AND AWARDS

2019 Graduate Student Travel Award: Susan Bulkeley Butler Center for Leadership Excellence, Purdue University
$500 to support conference travel to present research

2019 PROMISE Award: College of Liberal Arts, Purdue University
$750 to support research

2018 Bruce Kendall Award for Excellence in Teaching: Brian Lamb School of Communication, Purdue University
Award to recognize a graduate student for excellence in instruction, research, and service

2018 Certificate of Foundations in College Teaching: Center for Instructional Excellence, Purdue University
Certificate earned upon completion of a series of workshops and guided reflections based on evidence-based teaching practices and strategies.

2018 Brian Lamb School of Communication Service Award: Brian Lamb School of Communication, Purdue University
Award to recognize a graduate student who has maintained a solid academic record and
demonstrated exceptional and sustained service to the school and university

2018 PROMISE Award: College of Liberal Arts, Purdue University

	$1500 to support research
2017	Top Paper Award: Peace and Conflict Communication Division, National Communication Association (NCA)
2017	Competitive Conference Travel Grant: Communication Graduate Student Association, Purdue University $100 to support conference travel
2016	W. Charles Redding Graduate Fellowship Award: Brian Lamb School of Communication, Purdue University Summer endowment to recognize and reward outstanding graduate students
2015-2016	Ross Fellowship Award: Graduate College, Purdue University Competitive 4-year award package for outstanding Ph.D.-track students to graduate programs at Purdue University

INVOLVEMENTS AND SERVICE

2018-present	Conference Paper Reviewer for Health Communication Section National Communication Association
2017-2019	Mentor for Com 114 Mentoring Program Brian Lamb School of Communication, Purdue University
2016-2019	Judge for Com 114 Test-Out Brian Lamb School of Communication, Purdue University
2015-2019	Member of Communication Graduate Student Organization Brian Lamb School of Communication, Purdue University
2015-2019	Graduate Student Recruitment Representative Brian Lamb School of Communication, Purdue University
2018	Graduate Student Representative for Faculty Hiring Committee Brian Lamb School of Communication, Purdue University
2018	Conference Panel Chair for Organizing and Multiple Levels and Types of Identities, Organizational Communication Section International Communication Association
2018	Reviewer for *Health Communication*
2018	Conference Panel Chair for Issues in Organizational Communication Communication Graduate Student Association, Purdue University

2017	Conference Paper Reviewer for Student Caucus Section Central States Communication Association
2017	Conference Paper Reviewer for Student Section National Communication Association
2016-2017	President of Communication Graduate Student Organization Brian Lamb School of Communication, Purdue University
2015-2016	Member at Large of Communication Graduate Student Organization Brian Lamb School of Communication, Purdue University
2010-2014	Member of Communiqué, graduate student organization School of Communication, Western Michigan University
2010-2014	Member of Graduate Student Association, Western Michigan University

PROFESSIONAL MEMBERSHIPS

2018-Present	International Communication Association
2015-Present	American Academy on Communication in Healthcare
2014-Present	Central States Communication Association
2014-Present	National Communication Association
2013-Present	Michigan Academy of Science Arts and Letters
2008-Present	American Communication Association