2007

Managing Multiple Identities: A Qualitative Study of Nurses and Implications for Work-Family Balance

Claire Marie Spanier
The University of Montana

MANAGING MULTIPLE IDENTITIES: A QUALITATIVE STUDY OF NURSES

AND IMPLICATIONS FOR WORK-FAMILY BALANCE

By

Claire Marie Spanier

B.A. Communication, College of Saint Benedict, Saint Joseph, MN, 2005

Thesis

presented in partial fulfillment of the requirements
for the degree of

Master of Arts
in Communication Studies

The University of Montana
Missoula, MT

Spring 2007

Approved by:

Dr. David A. Strobel, Dean
Graduate School

Dr. Gregory S. Larson, Chair
Communication Studies

Dr. Christina Yoshimura
Communication Studies

Dr. Kathy Kuipers
Sociology

Spanier, Claire, M.A., Spring 2007   Communication Studies

Managing Multiple Identities: A Qualitative Study of Nurses and Implications for Work-Family Balance

Chairperson: Dr. Gregory S. Larson

The ways in which people manage organizational, professional, and familial identities can have significant implications for work-family balance. This is particularly true for nurses, who have a strong sense of professional identity and may be likely to experience work-family tensions. By framing work-family tensions as related to identity, we can see the ways in which being a "good" employee, a "good" nurse, and a "good" family member are both complementary and contradictory. This study highlights ways in which being "good" employee facilitates and hinders an individual's ability to be a "good" nurse. Furthermore, it demonstrates how being a "good" nurse can complement and contrast what it means to be a "good" family member. Furthermore, this study reveals the importance of one's peer group in the construction of identity.

This study offers several theoretical implications pertinent to the field of organizational communication as well as practical implications for health service organizations. Among other things, this study provides empirical evidence that reinforces the communication-identity relationship. Furthermore, it reveals ways in which the boundaries between identities are often blurred. It also presents practical implications for reducing burnout and volunteer turnover in nurses. In particular, it suggests ways in which organizations and nursing educators can work with organizational, professional, and familial identities to create policies and practices that improve work-family balance.

AKNOWLEDGEMENTS

"Education is not the filling of a bucket, but the lighting of a fire." – WB Yeats

My time in Missoula has been one of extensive personal growth and development. I have learned so much about academia and communication and even more about life. I would like to thank some of those who have kindled (and at times reignited) my spark, those who have taught me so much.

To begin, I would like to say thank you to my advisor, Dr. Greg Larson, who endured several "shitty first drafts" and countless topic changes. His feedback helped me to clarify my arguments and say something "meaningful." I would also like to thank my other committee members, Dr. Kathy Kuipers and Dr. Christina Yoshimura. They provided invaluable insight and guidance. Thank you all so much.

I want to thank my friends and fellow graduate students for great conversations that enabled me to grow both as a person and as scholar. They are a dynamic, engaging, and intriguing group of individuals. I have learned so much from them.

To my parents, I extend my deepest gratitude. They have been a continuous source of inspiration, love, and support throughout this experience. After receiving countless calls to complain, cry, or some combination thereof, they were a constant source of encouragement. In addition, I must thank my brother, Mark, who kept me from taking life, or myself, too seriously.

Finally, I must extend a great thank you to Brian Wavinak. When anxiety, frustration, and stress took a prominent place in my life, he patiently listened as I cried, rambled, and vented. I could not have done this without him.

To the Communication Studies faculty, my committee members, and my friends and family, I want to once again extend my heartfelt appreciation. Thank you.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION AND RATIONALE

On a cold, blustery February afternoon, Carol is making the final rounds of her afternoon shift at Mercy Hospital when her supervisor asks, for the third time that week, if she could stay an extra four hours. After twelve-hours, Carol is physically and mentally exhausted. She glances at her watch; it reads 3:45 p.m. She had hoped to make her daughter's seventh grade basketball game. She wants to be a good parent, to be there for her children, to support their activities. At the same time, she knows that if she tells her supervisor "no," the other nurses will have to work twice as hard to get everything done. She wants to be a team player, to share the responsibility. She cares about her patients; they need her. She wants to do it all, but cannot see how that is possible.

Carol's dilemma is not uncommon in modern United States society, as many individuals are forced to negotiate a series of competing roles or identities. In the above scenario, Carol simultaneously tries to manage being a "good" employee, who is willing to work overtime, a "good" parent, who goes to basketball games, and a "good" nurse, who is a team player who cares about her patients.

Prior to the industrial revolution, there was little distinction between home life and work life. As a result being a "good" family member was synonymous with "good" employee. All family members were expected to contribute to the family's work. In the early twentieth century, with the industrial revolution, paid labor left the homestead and moved into the factory. As a result, work and family were divided into two distinct realms. One was a "good" employee while at work, "good" family member at home, and the two were never to mix.

However, the idea of two separate spheres represents an overly simplified way of examining work-family tensions. In the latter part of the twentieth century, dual-career families have become increasingly common, if not the standard. In fact, the Bureau of Labor (2005) estimates that approximately 61 percent of the United States' workforce is comprised of dual-career families with children. As a result, men and women across the country must reexamine the ways in which they manage work-family tensions. Specifically, they must negotiate being "good" family members and "good" employees.

To begin, this study offers a unique look at work-family tensions by framing them as identity negotiation. Existing research often describes work-family tensions as related

to boundary management. Work and family are two arenas, and the level of work-family balance is dependent upon the ways in which individuals create rigid or fluid boundaries (Nippert-Eng, 1996). Poor work-family balance, with inefficient or incorrect boundary management, arises when responsibilities or stresses from one area spill over into another (Burke & Greenglas, 1987; Piotrkowski, 1979). When home life enters into the workplace, it may create problems. When work demands infringe on one's personal life, additional problems may arise. Frone, Russell, and Cooper (1991) describe the ways in which poor boundary management, when one area invades another, often results in various forms of psychological and physical problems.

This extant research often looks at specific behaviors and assesses the degree to which they integrate or segment the boundaries between work and family. For example, interpersonal researchers have examined ways in which people use individual behaviors, such as telework, to blend or separate work and family (Hill, Hawkins, & Miller, 1996). In addition, Golden (2002) describes ways spouses devise ways to negotiate work-family tensions. From an organizational perspective, Thompson, Beauvais, and Lyness (1999) have studied the factors that influence whether or not employees will use organizational policies, such as maternity leave. This research often labels behaviors as integrating or segmenting. When individuals, dyads, or organizations use integrating behaviors, they focus on the ways in which work and family can complement one another. For example, an organization's use of telework or telecommuting suggests that work and family can occur simultaneously and facilitate each other. Meanwhile, when individuals, organizations, or dyads feel that work and family do not work well together, the use of segmentation strategies, such as flextime, is more likely. These strategies reinforce the separation between work and family, but aim to promote work-family balance by providing flexibility.

It is important to note that, while these behaviors can be characterized in terms of aligning more strongly within an integration or segmentation framework, they may be experienced differently for each individual. By framing work-family tensions as identity negotiations, one can see the ways in which different aspects of work and family simultaneously can be integrated and separated, complementary and conflicting.

Identities are created through communication, through discourse (Larson & Tompkins, 2005). In turn, people's identities influence their communication behaviors, which then shape their identities. Organizational communication scholars, Putnam, Grant, Michelson, and Cutcher (2005), explain how "discourse and organizational processes are mutually constituted" (p. 7). In this way, what it means for Carol to be a "good" employee, a "good" nurse, and a "good" family member are "texts" that are created through communicative behaviors. These "texts" are then created, distributed, and used in organizations. In essence, in this discursive approach to work-family tensions, the texts (the communication discourse) promote specific behaviors that define these texts. Identity creates and is created by discourse.

By examining the ways in which nurses manage being "good" employees, "good" nurses, and "good" family members, this study presents a unique way to examine work-family tensions. Subsequently, it provides implications that are both theoretical and practical. In particular, it reveals the ways in which work-family tensions may be complementary and contradictory. It reinforces the communication-identity relationship and explores the boundaries between various identities.

Instead of framing work and family as either complementary or contradictory, this study looks to examine the ways in which they are both complementary and contradictory. Furthermore, by examining the identification with employee, nurse, and family role, this study provides a way to understand both what nurses do as well as some of the value premises that guide what they do in terms of work-family tensions. Miller, Jablin, Casey, Lamphear-Vanhorn, and Ethington (1996) explain how the decision to take maternity leave is not simply a matter of availability. Instead, they explain how maternity leave (behavior) includes a negotiation of one's role. This study complicates the work-family tension discussions by incorporating the ways in which nurses manage organizational, professional, and familial identities.

This study also presents several practical implications for health-service organizations and the field of nursing. In particular, by understanding the ways in which nurses manage multiple identities, health service organizations may be better able to create policies and programs that better facilitate work-family balance or reduce burnout and turnover. Although it is not likely that organizations or individuals will be able to

eliminate work-family tensions, it may be possible to identify the ways in which individuals may more competently negotiate tensions, minimizing the negative consequences (e.g., depression). Kirby, Golden, Medved, Jorgenson, and Buzzanell (2003) argue that a communicative approach to work-family issues provides an avenue in which communication may act as a "catalyst for empowerment," noting that "communication can allow workers to negotiate arrangements at work and at home to achieve 'balance' or whatever ends they seek" (p. 2). Therefore, a discursive approach may provide insight into the ways in which informal, local-level resistance efforts (e.g., bitching) influence and shape more formal resistance efforts. Furthermore, by including professional identity into the work-family negotiation, health service organizations and the field of nursing may be able to challenge values that create more work-family tensions while reinforcing those that reduce work-family tensions.

Finally, by understanding where nurses learn what it means to be "good" employees, "good" nurses, and "good" family members, this study provides a way to see areas for empowerment. For example, Kirby and Krone (2002) suggest that coworkers may have a greater influence on individual work-family negotiation behaviors than official organizational policies. Nippert-Eng (1996) explains that, regardless of formal policy, "work groups let us know if we actually have flexible working hours and places" (p. 188).

Organizations are inherently tension-filled; specifically, an individual's actions influence identity while one's identity then influences his or her actions (Scott, Corman, & Cheney, 1998). Most research on organizational identity has focused on ways in which organizations inculcate members with their beliefs and values (Tompkins & Cheney, 1985) or the ways in which individuals, independently, negotiate their identities (e.g., Holmer-Nadesan, 1996). To negotiate or manage these identity tensions, nurses may look to others (e.g., family members, coworkers) as a guide for what is possible or acceptable.

Thus far, I have established a rationale for this study, pointing out its social significance, theoretical implications, and practical applications. In the next chapter, I will review some of the relevant literature and present three research questions used to guide this study. Then I will describe the method of inquiry and answer the research questions.

CHAPTER 2: REVIEW OF RELEVANT LITERATURE

WORK-FAMILY TENSIONS

Kirby, et al. (2003) explain that existing work-family research often situates work and family as two distinct areas, two spheres, and examines the ways in which these spheres are balanced or not balanced. They explain that this research often looks at work-family balance as an outcome by asking questions such as "Does this individual have work-family balance?" or "Person A has poor work-family balance, what are the negative effects of poor balance?" However, few of these studies highlight the central role communication plays in "(re)constituting work-family meanings and consequences" (Kirby, et al., 2003).

Work-family tensions have been studied in a variety of disciplines (for reviews see Gonyea & Googins, 1992; Loscocco & Rochelle, 1991; Voydanoff, 1989). Regardless of the field, these studies often position work and family as two competing arenas. For example, Greenhaus and Beautell (1985) quantitatively measure the amount of "work-family conflict." They explain that this conflict is likely to occur when (1) one's work-role or professional identity conflicts with his or her other life roles (role conflict), (2) time spent on one activity, such as work, reduces the amount of time a person has to spend on another activity, such as family (time-based conflict), (3) stress in one area may spill over into another area (strain-based conflict), and (4) behaviors appropriate for one area may not be appropriate in another (behavior-based conflict). Within this framework, work and family are inherently conflicting.

DISCOURSE AND IDENTITY

Tracy and Trethewey (2005) note, "the self is seen as neither fixed nor essential, but instead, as a product or an effect of competing, fragmentary, and contradictory discourses" (p. 168). As a result, individuals simultaneously possess several different, often competing, identities. Describing multiple identities does not constitute a dichotomy between a real and fake self. Instead, an individual's sense of self is created through the negotiation and management of these multiple identities (Tracy & Trethewey, 2005).

Identities are not static nor are they inherited. Instead, people's sense of self is continuously created and recreated through everyday actions (Scott, Corman, & Cheney,

1998). In turn, their everyday actions influence their understanding of who they are. For example, an individual may state, "Because I am a good employee, I will work overtime," or "Because I work overtime, I am a good employee."

Organizational life has become increasingly more complex (Trethewey & Ashcraft, 2004). As a result, Trethewey and Ashcraft (2004) note that individuals are often "pulled or are purposefully moving in different, often competing directions" (p. 81). Individuals' multiple identities do not always work in tandem; instead, they frequently challenge each other. As a result, managing organizational tensions and managing the tensions created by multiple identities represents "routine features of organizational life that attest to the functional irrationality of organizing" (Trethewey & Ashcraft, 2004, p. 83).

Identities are not static entities. Instead, Scott, Corman, and Cheney (1998) present a structurational model of organizational identity and identification. This model describes identification as a communication process through which organizational members create, maintain, and reshape their identities. They describe identity as the "core beliefs or assumptions, values, attitudes, preferences, decisional premises, gestures, habits, rules, and so on" that make up an individual's sense of self (Scott, Corman, & Cheney,1998, p. 303). Highlighting the structure-agency aspect of organizational identity, they explain how identities represent "rules" and "resources" that organizational members use to influence their behaviors.

Scott, Corman, and Cheney (1998) distinguish between identity and identification. Identity refers to individuals' understanding of who they are, while identification represents the communication behaviors whereby individuals enact the values that comprise their identities. Identity and identification are mutually (re)created. Larson and Pepper (2003) describe identity as the structure (e.g., values) and identification as the communicative behaviors that reflect and create the structure.

Furthermore, people do not have one single identity. An individual's sense of self is fragmented and includes identities defined by social relationships (e.g., mother, daughter, aunt), organizational memberships (e.g., hospital employee, nurse, Methodist). As a result, individuals can be described as prisms whereby several identities are continuously reflected and refracted in a variety of ways (Tracy & Trethewey, 2005).

WORK-FAMILY TENSIONS AS IDENTITY ISSUES

Work-family tensions may be framed as identity tensions. While people embody multiple identities (e.g., employee, family member), the values important to being a "good" employee may be incongruent with what it means to be a "good" family member. Furthermore, embracing a particular identity highlights the importance of the identity's value premises (Tompkins & Cheney, 1985). For example, enacting an organizational identity that encourages efficiency may influence the ways in which this value plays out in other identities (e.g., familial identity). Miller, et al. (1996) explain how, for women, the decision to take (or not take) maternity leave is not only a matter of availability (does the organization have a maternity leave policy). Instead, it represents a form of identity negotiation whereby expecting parents manage what it means to be a committed employee as well as a committed parent.

Further complicating the work-family discussion is professional identity. Many occupations (e.g., nursing) promote a high degree of professional identification (I am a "good" nurse) in addition to organizational identification (I am a "good" employee). For example, if they were nurses, the expecting parents in Miller et al.'s (1996) study may have to consider what it means to be a committed nurse as they contemplated the decision to take maternity leave. For people who identify strongly with a particular profession, work-family negotiations may be even more complex.

Several scholars have highlighted ways in which members manage multiple identities. For example, Larson and Pepper (2003) describe three discursive strategies used by organizational members to justify their negotiation of multiple identities: comparison, logic, and support. Through comparison, organizational members measured their decisions against a standard set by their peers. Logic involved making "rational justifications" for negotiation outcomes (p. 544). Finally, when employing support, members sought out others to justify a decision. Through comparison, logic, and support, organizational members were able to manage the tensions created by conflicting identities.

NURSES: THREE KEY IDENTITIES

Work-family tensions have become increasingly important discussions within the nursing profession as health service organizations strive to reduce burnout and turnover.

As described, three identities (organizational, professional, and familial) may be particularly salient for nurses' work-family discussions.

<div align="center">"Good" Employee</div>

Nursing is paid labor. As a result, nurses are asked to be "good" employees of a particular health service organization. Nurses may work in a variety of organizations, such as hospitals, nursing homes, clinics, birthing centers, and schools. Further, nurses may work at large hospitals in very specialized areas (e.g., neonatal intensive care unit), or they may work for smaller hospitals where they are asked to perform a variety of tasks of a daily basis (e.g., delivery and obstetrics, oncology).

In addition, nurses may occupy several positions within these organizations, such as administrator, manager, or record keeper. Their position within a health service organization may be a reflection of their educational level (e.g., licensed practical nurses, registered nurses, advanced practice nurses or nurse practitioners). After passing a state examination, licensed practical nurses (LPN) are able to administer medications and treatments under the supervision of a registered nurse or physician (Bureau of Labor, 2006), meanwhile registered nurses (RNs) must complete a formal nursing education program such as a four-year baccalaureate or two-year associate degree) (Bureau of Labor, 2006). Registered nurses often direct, coordinate, and supervise the activities of certified nursing assistants and licensed practical nurses and provide hands-on care to patients (Bureau of Labor, 2006). Malone and Marullo (1997) note that registered nurses make up the largest section of the healthcare workforce. Because of they possess a degree beyond that of registered nurses or licensed practical nurses, advanced practice nurses may be able to diagnose illnesses and prescribe medications (Bureau of Labor, 2006). They may also do work in research, education, and administration (Bureau of Labor, 2006).

As a part of a health service organization, being a "good" employee means adherence to the organization's values. For example, the Mayo Clinic describes idealism, teamwork, commitment to excellence, learning, and innovation as primary values that define the organization's culture (Mayo Clinic, 2006). The Birth Center in Missoula, Montana describes "Complete health care for women and their families" and "the

partnership between provider, staff, and client" as values important to the organization (The Birth Center, 2007).

Although the values of each health service organization may differ somewhat, it can be argued that patient care is likely to be a core value. For health service organizations, patients are customers. As a result, to remain active, health service organizations must meet the needs of their patients.

<div align="center">"Good" Nurse</div>

While there were nurses before her, Florence Nightingale dramatically changed the conceptualization of professional nursing when, during the Crimean War, she set out to care for wounded soldiers (Dossey, 2000). As a result, she is often described as the mother of professional nursing (Evers, 2001). In her *Notes on Nursing*, Nightingale (1860/1969) emphasized the importance of naming nurse as a profession. Her influence in the field is seen in the Nightingale Pledge, which, due to her influence carries her name. This pledge is similar to the Hippocratic Oath and is often used during initiation ceremonies to welcome new nurses into the profession. The pledge reads:

> I solemnly pledge myself before God and in the presence of this assembly:
> To pass my life in purity and to practice my profession faithfully;
> I will abstain from whatever is deleterious and mischievous and will not take or
>   knowingly administer any harmful drug;
> I will do all in my power to maintain and elevate the standard of my profession and will
>   hold in confidence all personal matters committed to my keeping all family
>   affairs coming to my knowledge in the practice of my calling:
> With loyalty will I endeavor to aid the physician in his work and devote myself to the
>   welfare of those committed to my care.
> (American Nurses Association, 2006)

This oath summarizes what may be the core components of a "good" nurse. Dock and Stewart (1937) argue that it is imperative for nurses to understand the profession's history. A "good" nurse is one who is committed to caring for others, works to elevate the standard of the profession, and is committed to the physician.

<div align="center">*Commitment to Care*</div>

The commitment to care underpins much of nurses' professional discourse. Henderson's (1960) definition of nurse' responsibility "to assist individuals (sick or well) with those activities contributing to health, or its recovery or to peaceful death, that they perform unaided, when they have the necessary strength, will, or knowledge; to help

individuals carry out prescribed therapy and to be independent of assistance as soon as possible" (as cited in Evers, 2001, p. 137). Nurses are to feel a connection to those in need (e.g., the sick, the dying); through this connection, they are to do whatever they can to help their patients.

Discussions of the importance of compassion are common throughout nursing education and scholarship. For example, in 1989 nursing scholars gathered in Houston, Texas to reinforce the importance of caring in the nursing profession. At this conference, Roach presented a keynote address titled "The Call to Consciousness: Compassion in Today's Health World" where she challenged participants to explore the commitment to caring. Additionally, nursing scholars have provided practical advice and theories in regards to caring and compassion in the workplace. For example, Halldorsdottir (1991) highlights five ways of interacting with others that include caring and non-caring dimensions: life-giving, life-sustaining, life-neutral, life-restraining, and life-destroying. Nurses are to embrace life-giving interactions while refraining from those that restrain or destroy life. The commitment to compassionate caring remains at the forefront of academic and experiential nursing discussions.

Advancement of the Profession

From the earliest days, when Nightingale defined what nursing is and is not, nurses have been charged with the task of advancing the profession. This is particularly important because taking care of the ill has been colloquially described as "natural," a mere extension of domestic roles rather than a highly technical skill (Palmer, 1993). Palmer (1983) and Porter (1992) describe how the nursing profession has been classified (to varying degrees) as unskilled and devalued labor, especially in comparison to other healthcare occupations (e.g., physicians). As a result, they explain the importance in working to establish the profession's reputation

To advance the profession, nurses are often asked to embrace leadership skills and work as educators. For example, Weingarten (1999) describes ways in which faculty can work to develop leadership skills in nursing students. Specifically, she highlights ways to develop leadership in classroom settings, in clinical courses, and through interdisciplinary collaboration. Meanwhile, Foley (1999) describes ways in which nursing associations can

foster leadership skills for staff nurses. Others have described the importance of mentoring to the profession's advancement (Andersen, 1999; Vance, 1999).

In addition to working as leaders, both in their communities and in their health service organizations, "good" nurses are also asked to serve as educators. During their education, nurses may be asked to take courses in pedagogy and adult learning. Through these courses, they may be taught the broad theories underlying instructional approaches as well as given practical advice, such as how to evaluate instructional materials (Bastable, 2003). In this way, nurses' work leaves the health service organization and enters the community.

Commitment and Deferment to Physician

While nurses are expected to be knowledgeable in regards to specific procedures, treatments, and policies, they also may be expected to work within a hierarchical relationship (physician-nurse). Dolan, Fitzpatrick, and Hermann (1983) note that while there may be anecdotal accounts of nurses standing their ground in defiance to a physician, the general value premise reinforces the idea that when a physician and nurse disagree, a "good" nurse will defer.

"Good" Family Member

Like nursing, being a "good" family member is often described as something that comes naturally. Anecdotal accounts suggest that "good" family members should be able to provide for their families, emotionally, financially, or both. In particular, being a "good" family member is often described in terms of being a "good" parent. There is no shortage of parenting suggestions from popular media or one's social network. While the specifics may vary, two common themes seem to persist. In short, "good" family members and "good" parents are (1) caring, compassionate, and loving and (2) involved in family members' (e.g., children's) lives.

"Good" family members are described as loving and caring. They express warmth and affection genuinely and frequently. In a popular parenting advice book Steinberg (2004) argues that loving and respecting one's children is the most important factor to healthy development. Patient and empathetic, "good" family members foster relationships and provide social support. In addition to being loving, "good" family members are involved in the lives of those they care about. On it's website, the American

Academy of Family Physicians (2007) advises parents to spend time with their children by doing things together and attending children's extracurricular activities (e.g., sporting events).

<div align="center">Complementary and Competing Identities</div>

Through a broad understanding of the possible value premises that define what it means to be a "good" employee, a "good" nurse, and "good" family member, one can identify several potential areas where these identities may conflict and complement each other and implications for work-family balance.

For example, one of the greatest challenges to nurses' work-family balance may be a result of the profession's job description. People need medical care, in various forms, all day, every day. As a result, nurses' schedules may be particularly demanding. Furthermore, nurses may be asked to work longer shifts over fewer days. For example, instead of working eight hours a day, five hours a week, a nurse may be asked to work three to four twelve hour shifts per week.

In addition, when nursing work is described as "natural" rather than technical, it is devalued. Such work is less likely to demand large wages, especially for nurses with less education and training. As a result, nurses may have to work more hours in an effort to meet their financial responsibilities, increasing the tension between "good" employee and "good" family member.

Nurses, like "good" family members, are often expected to have an endless supply of emotional energy to expend on their patients. However, this can create complications when trying to manage work and family responsibilities. For example, after an exhausting 12—hour shift, a nurse may be "all cared out." As a result, it can be difficult to be both a "good" nurse and a "good" parent.

The emphasis on caring and compassion, in turn, may simultaneously facilitate and hinder being a "good" family member. For example, these characteristics are also praised in personal relationships. It is important for a parent to be loving and caring. However, when a nurse is expected to constantly be emotionally available, to constantly care and be compassionate, it may increase work-family tensions.

However, a cursory understanding of the values and premises defining "good" employees, "good" nurses, and "good" family members can only theorize about possible

ways in which these identities complement and conflict with each other. As a result, two research questions are posited in the current study.

RQ1: In what ways do the meanings for "good" employee, "good" nurse, or "good" family member complement each other?

RQ2: In what ways do the meanings for "good" employee, "good" nurse, or "good" family member conflict with each other?

IDENTITY DEVELOPMENT

"Good" Employee

Individuals learn what it means to be a "good" employee, a "good" nurse and a "good" family member from a variety of sources. To begin, nurses' understanding of what it means to be a "good" employee at a specific health service organization is often promoted through formal organizational training where nurses are asked to identify with the organization's values and principles.

In addition, managers in health service organizations often seek nurses' identification through self-managed work teams (Tappen, 2001). The use of self-managed work teams has become a popular organizational practice for several reasons, most importantly the focus on organizational identification. Barker (1999) states, "Self-managing teams fit best in organizations characterized by interdependent tasks, complex processes, time sensitivity, and the need for rapid change and adaptation" (p. 3). A healthcare facility often exemplifies all of these characteristics. Nurses must complete complex and interdependent tasks while being efficient and adapting quickly to changing situations.

"Good" Nurse

Nurses' occupational identity often begins well before they gain employment into a particular health service organization. Some nurses may say they knew from a very early age that they wanted to be a nurse. Furthermore, nursing is a profession with which individuals of all ages come into contact on a semi-regular basis (e.g., school nurse, routine physical exams). This provides an opportunity for prospective nurses to see these individuals as role models from whose behavior they can discern what it means to be a "good" nurse.

An understanding of what it means to be a "good" nurse, to adhere to a professional or occupational identity, is enhanced through formal education. All nurses are required to complete specific training (Bureau of Labor, 2006). Nurses must often complete this training outside of the employing organization and pass a national licensing examination, such as the NCLEX-RN, in order to obtain a nursing license (Bureau of Labor, 2006).

Unlike other academic fields (e.g., communication), where individuals' eventual career paths are not strictly determined by their field of study (e.g., communication majors do not automatically become "communicators" upon completion of their degree) nursing students can almost immediately begin work as nurses. During educational training, nurses are indoctrinated with the professions values and norms. In addition to receiving theoretical and practical knowledge, nursing students also learn what it means to be a "good" nurse. The creation of this value system represents the initial formation stage of concertive control outlined by Barker (1999). Here, nurses are given a vision statement (e.g., Nightingale Pledge) to be used as a decision-making guide.

Throughout their on-the-job training, prospective nurses are taught how these values are to guide their behaviors in everyday practice. This represents Barker's second phase, where new members are brought in and longer-tenured members teach these new members the group's values and norms. Through this phase, nurses may learn what is considered an appropriate behavioral manifestation of a particular value. For example, new nurses may learn what is considered an acceptable or appropriate amount of time to spend with a patient (Gordon, 2005).

Furthermore, nurse may be encouraged to join and become in professional organizations (Fetters, 1999). Through involvement with these larger organizations, nurses are asked to see themselves a part of a greater professional network, rather than a small cohort at a particular health service organization.

While researchers have suggested ways in which people may learn the values that define various identities, no empirical evidence has been provided to show how nurses learn these particular values and identities. Therefore, this study asks a third research question.

RQ3: How do nurses learn what it means to be a "good" employee, a "good" nurse, or a "good" family member?

SUMMARY

This section has reviewed the existing research on work-family tensions and argued that it is fruitful to frame these tensions as identity issues. In addition, this study asks how organizational, occupational, and familial identities are both complementary and contradictory. In addition, while the preceding section has suggested ways in which nurses may learn what it means to be a "good" employee or a "good" nurse, this study asks where nurses learn what it means to be "good." To conclude, the following research questions guide this study.

RQ1: In what ways do the meanings for "good" employee, "good" nurse, or "good" family member complement each other?

RQ2: In what ways do the meanings for "good" employee, "good" nurse, or "good" family member conflict with each other?

RQ3: How do nurses learn what it means to be a "good" employee, a "good" nurse, or a "good" family member?

CHAPTER 3: METHODS

OVERVIEW

In the first two chapters, I provided a rationale for completing this study and reviewed relevant literature. I then stated four research questions that guided the current study. To answer these questions, I interviewed thirty nurses in River City. In this chapter, I begin by describing the participants and procedures used to collect the data. I conclude by explaining the methods and tools used for data analysis.

PARTICIPANTS

Participants included nurses from a variety of work contexts and positions. Of the thirty participants, 12 worked in hospitals and/or birthing centers, six in nursing homes, six in clinics, and three described their work environment as home health or hospice. Twelve participants were licensed practical nurses, one of whom was currently working towards a Bachelor of Science in nursing. Fifteen were registered nurses, one of whom was working towards an advanced nursing degree. Three held advanced degrees in nursing and worked as nurse practitioners.

Participants' nursing experience spread from ten months to more than 30 years; most participants had worked as nurses for 10-20 years. All participants worked full time at the time of the interviews, though three mentioned that they had worked reduced schedules throughout their career, and one explained that she had a period of four years where she did not work as a nurse. Additionally, all participants had at least one child living with them at home, though the age of children ranged from infants to 18 years of age. Finally, 27 of the participants were women. While this ratio appears skewed, it reflects the gender distribution in the nursing profession. (Bureau of Labor, 2006).

PROCEDURES

Participant Procurement

Upon receiving approval from the Institutional Review Board, I began collecting data to complete the project. The study utilized responses from thirty nurses who work and/or live near a mid-sized town in the West that will be referred to as River City. Because I wanted to look at nurses in general, rather than as members of particular health service organization, I used a snowball sample data-gathering technique (Lindlof & Taylor, 2002) to procure research participants. I began my initial sample by asking

friends and colleagues if they knew nurses in River City who would be interested in participating in a research study. Requisite qualifications to participate included (1) being currently employed full time as a nurse and (2) living and/or working in River City. After receiving potential participants' contact information, I called or emailed them to describe the study and ask if they would be willing to participate.

After participants agreed to be interviewed, I scheduled interviews at times and locations that best fit the participants' schedules. Interviews were conducted in several locations: break rooms, individual offices, exam rooms, birthing rooms, coffee shops, homes. Twenty of these were completed while the participant was at work (before beginning a shift, during a break or lull, immediately after completing a shift), while the remaining ten were completed at other times.

At the end of each interview, I asked participants if they knew any other nurses in the River City area who would potentially be interested in participating as well. At the end of some interviews, participants would go to their coworkers and ask them to participate at that moment. As a result, some of the participants were grouped according to cohort (e.g., three members of an overnight obstetrics shift). Several participants mentioned that they had friends and colleagues who would be interested, but did not know the full contact information at the time of the interview. Therefore, I provided participants with my contact information and asked them to call or email me with the names of their friends or coworkers. After one week, if I had not heard from them, I called participants to check in and see if their friends or colleagues were interested in participating. I continued the snowball sample until I had interviewed thirty participants.

<div align="center">Instrument</div>

To complete this study, I used a series of semi-structured interviews. Lindlof and Taylor (2002) suggest that semi-structured interviews enable one to guide an interview, rather than strictly direct it. The "structured" component of a semi-structured interview provided enough stability across interviews, thereby making it easier than unstructured interviews to compare responses. Additionally, because they are only semi-structured, the interviews had enough flexibility to allow me to adapt to changing situations and gave participants the opportunity to add or highlight new ideas (Lindlof & Taylor, 2002).

Interviews were used to understand participants' experiences and perspectives regarding identity and identifications (Lindlof & Taylor, 2002). I used an interview guide, which consisted of four major areas (definitions, complementary identities, conflict identities, and gender). In addition to asking participants to describe what it meant to be a "good" employee, I asked participants to provide accounts or narratives of people or situations that exemplified the qualities of a "good" employee. Additionally, I also asked participants to provide narratives and accounts of specific instances where, for example, being a "good" nurse made it more or less difficult to be a "good" employee. In previous studies, researchers (i.e., Larson & Pepper, 2003) have used interviews that ask participants to provide accounts or narratives as a way to understand the core values that influence identity and identification. Furthermore, asking participants to describe situations where they managed these identities provides an avenue to see the value premises that guide individuals' decision-making (Tompkins & Cheney, 1985). By understanding the thought process that guided their decisions, one may be able to see the ways in which participants manage these identity tensions.

Several researchers have suggested that interviewing is a particularly interesting way to understand organizational identity and identification (Bullis & Tompkins, 1989; DiSanza & Bullis, 1999; Larson & Pepper, 2003; Larson & Tompkins, 2005; Tompkins & Cheney, 1985) and identity tensions specifically (Larkey & Morrill, 1995; Larson & Pepper, 2003). Larson and Pepper (2003) explain, "during the course of the interview conversation, the participants discursively construct understanding" (p. 537). Through this "interview talk," participants construct identity narratives and make sense of their own experiences. Through this verbal sense making, a researcher can attempt to discern the details that are or are not salient to the individuals' discussion of identity. To put it simply, by talking about and describing their experiences and identity (e.g., "good" nurse), participants allow researchers to understand their identities. Additionally, through these conversations, participants also reinforce and reshape their own identities, thereby enabling a researcher to see a glimpse of the identification process.

The current study asked participants to define what it means to be a "good" employee, to be a "good" nurse, and to be a "good" family member through providing specific accounts. Again, this provided two ways to understand the core values that

structure and shape identity. While specific values may be stated explicitly through descriptions, these values may also be discerned implicitly through examining the ways in which individuals talk about themselves and their experiences. Through these illustrations and anecdotes, one can see the ways in which core values implicitly defined their sense of self (e.g., as "good" nurse). Therefore, asking participants to describe their personal experiences provides an interesting way to understand what it means to participants to be "good" employees, "good" nurses, and "good" family members.

Interview Process

As described, interviews were conducted at a time and location that was most convenient for participants. I began each interview by stating my purpose. I explained that this project was being done in part to fulfill thesis requirements for an M.A. program. I emphasized that I wanted to know how they described or defined various ideas and concepts, such as what it meant to be a "good" nurse. I stated that my goal in this project was to understand the experiences of nurses in River City.

Second, I explained that participation in the project was optional and would require them to read and sign an informed consent form. I then explained that the interview would last between twenty minutes to one hour. Next, I presented the consent form and highlighted that their participation was voluntary and that responses would be confidential, with all names and identifying information removed from the final project.

Third, I asked participants if they had any questions about the project or their participation. Few participants had questions. Those who did, however, were most intrigued (confused) by the relationship between a communication scholar and nursing.

I then asked participants if they would be willing to be recorded on audiotapes that only I would be able to access. I also explained that they could ask me to stop recording at any time. They all agreed to be recorded, but asked for reassurance that I would not play the responses to their coworkers, supervisors, or medical transcriber employed in the area. Several of them explained that they were not concerned about the content of the interview; rather, they were embarrassed by the sound of their voice and did not want those they interact with on a daily basis to hear the recordings. To create a record of interview components not captured in the audio recordings (e.g., interview date, location, time), I also took handwritten notes during the interviews.

To conclude each interview, I asked if participants had any additional questions for me. During this time, most asked questions about my educational background, specifically, why a communication, not a nursing, student was completing such a project. Yet, almost all expressed their interest in the project. Wendy notes, "They never ask us [about work-family issues]. They just say, "Here, now we're doing it this way so you won't get burned out." But they never ask us, so it's really, it's nice to be asked." Many described how they rarely were consulted before a new policy, aimed at improving their work-family balance was implemented. I ended each interview by thanking participants for their participation.

DATA ANALYSIS AND INTERPRETATION

Data Preparation

After completing each interview, I transcribed it and the handwritten notes I had taken throughout the interview. To preserve confidentiality, I created pseudonyms for all participants and other identifying information (e.g., employer) during each transcription. I alternated between transcribing, interviewing, and preliminary analyses until I had finished all thirty interviews. To provide contextual cues for data analysis, I included nonverbal descriptions, such as laughter, in the transcriptions. However, to produce a more readable account, I eliminated the use of vocal fillers, such as "ah" or "um" in the final report while retaining these cues in the original transcripts. To test for accuracy, I listened to each recorded interview, compared it to the written transcript, and made corrections if necessary. In total, the interview transcriptions and notes yielded 298 single-spaced pages of text.

Analysis

While transcribing, I noted themes within each interview. After completing all transcriptions, I analyzed the data using a modified grounded theory approach (Lindlof & Taylor, 2002). First, I read all transcripts and notes, looking through the data for groupings of meaning (Marshall, 1981). I then combined these groupings with the initial themes I had recorded to create an initial coding scheme (26 initial codes). I then went through the data line by line and assigned each line a code (Strauss & Corbin, 1990). With each coding, I would compare it to the other previously coded lines and the preliminary coding scheme (Glaser & Strauss, 1967). Throughout this constant

comparison phase of data analysis, I looked to see if my data fit into the pre-existing theme set I had created and, if they did not fit, I created a new code. This, in turn, resulted in an additional two codes (ability to multi-task, ability to delegate) (Appendix C).

After sorting and analyzing the data according to the initial coding scheme, I used axial coding, where I looked for connections between the codes and categories in an effort to generate larger themes (Strauss & Corbin, 1990). I began this phase of data analysis by reviewing my research questions and comparing them to the collected data. I then took those responses that best answered each question and the codes that I had assigned those statements. Through this axial coding, I reduced my original twenty-eight codes into six themes (Appendix C).

Finally, in an effort to assess the accuracy of my analysis, I performed member checks with three participants and three nurses who were not a part of the study (Lindlof & Taylor, 2002). All six nurses stated that they saw my analyses as congruent with their own experience and the experiences of their peers. In particular, they noted that some of the themes I presented were felt and understood by them and their peers, but they had not taken the time to reflect on these previously as part of their own experiences.

CHAPTER FOUR: RESULTS

OVERVIEW

In the preceding chapter (Chapter 3), I provided an overview of this study's methodology. Specifically, I described the participants, explained and justified my method of inquiry, and outlined the procedures used to conduct this study. In this chapter, (Chapter 4), I will answer the research questions introduced in the second chapter. The research questions guiding this study include:

RQ1: In what ways do the meanings for "good" employee, "good" nurse, or "good" family member complement each other?

RQ2: In what ways do the meanings for "good" employee, "good" nurse, or "good" family member conflict with each other?

RQ3: How do nurses learn what it means to be a "good" employee, a "good" nurse, or a "good" family member?

RQ1: IN WHAT WAYS DO THE MEANINGS FOR "GOOD" EMPLOYEE, "GOOD" NURSE, OR "GOOD" FAMILY MEMBER COMPLEMENT EACH OTHER?

Nurses' understanding of what it means to be a "good" employee, to be a "good" nurse, and to be a "good" family member is complex. While participants expressed that meanings for these ideas may vary, their responses revealed several common themes. In particular, all participants expressed that being a "good" employee, a "good" nurse, and a "good" family member was important to their sense of self. In this section, I answer the first research question (RQ1), which asks: *In what ways do the meanings for "good" employee, "good" nurse, or "good" family member complement each other?* To answer this question, I asked participants to describe what it means to be a "good" employee, "good" nurse, or "good" family member and the ways in which they complement each other. In these responses, participants described ways in which being a "good" employee worked with being a "good" nurse as identified ways in which being a "good" nurse worked with and against being a "good" family member. Interestingly, participants did not highlight ways in which being a "good" employee worked with or against being a "good" family member. Instead, for participants, the nursing identity was particularly salient as "good" employee and "good" family member were framed in terms of ways in

which they enhanced or hindered (or were enhanced or hindered by) being a "good" nurse. Therefore, to synthesize their responses, I will first discuss the ways in which being a "good" employee facilitated being a "good" nurse (and vice versa). Second, I will describe the ways in which being a "good" nurse facilitates being a "good" family member (and vice versa).

<div align="center">"Good" Employee Facilitating "Good" Nurse</div>

For many participants, being a "good" employee was synonymous with being a "good" nurse. When asked what it meant to be a "good" employee at a particular health service organization, twelve participants responded in terms of what it meant to be a "good" nurse. For example, Margaret states:

> A good Grace Hospital employee. Wow. I guess to characterize one. They're hard workers. They're critical thinkers. What I liked about them, was compassion and caring. They're a bright group. Male and female. …. And they're really open and honest people. And I think that is probably what I've seen the best qualities in the nurses at Grace Hospital.

Similarly, Greta responds by asking, "Isn't a good employee the same thing as being a good nurse?" For nurses like Margaret and Greta, the terms "employee" and "nurse" were interchangeable: a "good" nurse is a "good" employee.

Throughout the interview data, one can see several ways in which being a "good" employee makes it easier to be a "good" nurse and ways in which being a "good" nurse facilitates being a "good" employee. Specifically, being a team player, modeling healthy behaviors, and demonstrating a commitment to patients were characteristics described as vital to both "good" employees and "good" nurses. Patrick explains, "You can't be a good nurse without being a good employee. I think you have to be both. You can be a good employee without being a nurse. You don't have to be a nurse to be a good employee. But to be a good nurse you have to be a good employee." In this comment, Patrick suggests that being a "good" employee is a prerequisite qualification to being a "good" nurse.

<div align="center">*Team Player*</div>

One area where being a "good" employee complements being a "good" nurse is teamwork. "Good" employees work together as a part of a team in order to provide patient care. Nancy states, "We're all part of a team. The EMTs who bring the patients in,

the physicians, the nurses; we all have to work together." Similarly, "good" nurses also work as a part of a team. Wendy explains:

> You've got to be a team player at a nursing home. You know what I mean? You need to work. It's a team effort. You can't do my job without your nursing assistants and the nurses and your charge nurse. It's all a team effort. There's no way you can take care of this many people without a team effort. If you don't have a team effort with this many people, you just can't do your job. You need to have everyone pitching in. You just can't do it. You have to work together and recognize that it's a team effort. They call the nurses that are in charge, the "team leaders." And that is what we are. We have to find a way to get everyone what they need with the staff that we have. Sometimes it's hard. But you couldn't do it without a team effort.

In this statement, Wendy describes how the ability to work as a part of a team, to be a team player, is important to being a "good" nurse and a "good employee." Being a "team player" is a somewhat vague; for nurses, dependability, leadership, and critical thinking define a team player.

Dependability

Dependability is an integral component of being a team player. "Good" employees and "good" nurses can be counted on to do their jobs and to do them well, with minimal supervision. Emma states:

> They're someone who always will do their work, and you don't have to always check on them and make sure they're doing what they're supposed to. A nurse that's doing a good job, doing their job properly, well, that's a good employee. A good nurse is someone who you don't have to check up on and make sure that they're doing a good job, that's a good nurse.

Andrea echoes this idea when she says, "I can count on a good nurse to be dependable. If I have to waste my time making sure she's doing what she's supposed to be doing, then that keeps me from being a good nurse." Nurses explained how they struggled to find enough time in their workdays to complete all of their tasks. As a result, those nurses or employees who need to be "checked up on" took time away from nurses' work with patients. In this way, "good" nurses' dependability enables them to be team players, which further enhances their ability to be "good" employees.

Leadership and Critical Thinking

In addition to being a dependable, a team player (and thereby a "good" employee and a "good" nurse) must also be willing to demonstrate leadership and critical thinking. Within a health service organization, nurses often must respond immediately to

unexpected emergencies. "Good" nurses are able to act as leaders, using critical thinking to assess and manage emergencies. Jalyn recalls a recent incident on a delivery ward:

> Sometimes the unexpected happens. … Like, the other day we had a baby that was born, and you know there were just all of these complications and things that could be going wrong. And the little thing just did not want to breathe, and it wasn't moving and stuff. And I think that the girls that happened to be there that particular day were amazing. They were new to our team, and they just kept cool heads and really stepped up. I tell you what, they got people there in a quick hurry and I mean they knew what to do and when to do it. You know. Without needing anyone else to tell them what to do. It was awesome because they really saved this little baby's life. That's for sure.

In this story, Jalyn emphasizes how "good" nurses are able to remain calm in emergencies and act quickly to lead their teams in stressful situations. Additionally, she talks about how these situations serve as arenas where new employees and nurses are able to prove themselves to their teams.

Participants explained that critical thinking is an important part of taking on a leadership role. Margaret emphasizes this point; she states:

> You know, I'm a very critical thinker. I just can't stand a nurse who pages me on every little thing. And I say, "You needed to look in the chart. You needed to be a critical thinker. You should look to the progress notes. You should have…" I like a nurse that takes a little bit of autonomy and kind of takes charge and takes care of her patient that way.

In this comment, we see the importance of being able to find information. Being "good" meant that people did not waste time by asking superfluous questions; instead, they are resourceful. This goes beyond a preferred behavior. "Good" nurses and "good" employees are committed to caring for their patients; to do so, they must work together as a team. A "good" nurses, as Margaret explains, "takes a little bit of autonomy and kind of takes charge." By taking the initiative and exercising critical thinking skills, people are able to show their commitment to their patients and team. In essence, "good" nurses and "good" employees are team players who are able to take on leadership roles and exercise critical thinking in an effort to meet the teams' goals.

Role Model of Health Behaviors

In addition to acting as a team player, "good" employees and "good" nurses should model healthy behaviors. Although this quality was explicitly described in only eight interviews, those respondents were passionate about this characteristic. To be a

"good" member of a health service organization, one should represent the overall mission of that organization, health. Jamie expresses this sentiment; she states:

> As people whose primary goal is to ensure the health of our patients, we need to represent these values in our personal lives. We need to take care of ourselves. Like, no one who works at [a health service organization] should smoke. How are we to tell our patients to stop smoking if we do it ourselves?

In this statement, we see the importance of reflecting the organizations values. Other respondents explained that "good" employees should eat a healthful diet, engage in regular exercise, and get a sufficient amount of sleep. Christina explains, "Everyone who works here should care about their health. Not just nurses. So I think that's an important part of being a good employee." Debbie, who works with public health education responds, "I spend all day telling students that they need to practice safe sex. ' Use a condom every time,' I say, 'get tested.' Nurses are no exception. Nurses need to get tested, too. You can't be a good nurse if you don't take your own advice." These comments reflect the idea that all health service employees, including nurses, should model healthy behaviors. This emphasis on maintaining a healthy lifestyle may facilitate being a "good" nurse and a "good" employee in two key ways. First, modeling healthy behaviors reflects both organizational values as well as professional values. For nurses and health service employees in general, proper healthcare is important. As a result, through behaviors that model good health practices, "good" employees and "good" nurses are able to demonstrate their adherence to the values that make up these identities. Second, in addition to reflecting organizational and professional values, modeling healthy behaviors may make it easier to be a "good" employee or "good" nurse by reducing absenteeism. For example, those who are frequently absent as a result of poor health practices, may find it difficult to be a committed team member or to provide the best possible care to one's patients.

Commitment to Patients

Throughout the responses, participants emphasized the importance of being a team player and modeling healthy behavior. Why is this important for members of health service organizations? "Good" employees and "good" nurses are to embody these characteristics and behaviors to demonstrate their commitment to their patients. Felicity states:

> If you're here five days a week, you're usually here 10-hour days, 11-hour days. But it's hard work. I mean, a lot of people I respect around here put in long days. They're extremely hard workers. And it's not for their benefit. It's NEVER for their benefit. Because the money isn't huge. You know, the benefit is always for, you know, the patient, and the service organization they serve.

In this quote, Felicity recognizes the importance of committing a large amount of time and energy into doing good work and explains that nurses are willing to spend so many hours working because they feel a commitment to care for their patients. Nichole, too, sees this selfless giving in her commitment to patients. She says, "You don't get into this job because the hours are great. You don't get into it because you're going to make a name for yourself. You get into it because you think it's important to care for others." A "good" nurse puts in these hours without expecting direct rewards. This facilitates being a "good" employee, as "good" nurses are likely to put in extra effort in the name of commitment to patient care.

It is important to note that the commitment to patients is not only important for "good" nurses; instead, to be a "good" employee, one needs to share this same commitment. Brianna remarks, "I guess that's the good part about healthcare now. The patients are customers. If they don't like something, they can take their business somewhere else. There's no loyalty. We have to show that we're working for them." Once again, in an effort to retain business, "good" employees are committed to their patients. Similarly, "good" nurses' sense of professional identity also encourages them to remain committed to patients' health. Although their motivations may differ somewhat, both "good" employees and "good" nurses are to be committed to their patients.

"Good" Nurse Facilitating "Good" Family Member

Although work and family roles are often depicted colloquially and in the research as pulling individuals in opposite, competing directions, several of the participants explained how being a "good" nurse facilitated their ability to be "good" family members (and vice versa). Jalyn states:

> Well, my supervisor would say they [work and family] they do [conflict]. She sees us with kids and thinks that it's so hard. She says "You know, you're so busy at home, and I feel bad." And you know, of course I would probably choose to be home more than I would choose to go to work. But I don't ever not want to go to work. I mean we all have our days when we don't really feel like working, but I never feel like I hate my job. Even when I'm at work, I'm still always thinking about my kids. I mean, for those people, especially those people with babies I know that it's hard to leave them and worry about

them. But I think more than anything I don't know if it really matters. If you like to come to work, then it's good for your personal development.

Participants saw a considerable amount of overlap between "good" nurse and "good" member in regards to the following areas: commitment to caring; critical thinking; teamwork; overall enjoyment or self-fulfillment. Specifically, through behaviors that reflect these aspects of the "good" nurse and "good" family member identities, participants reaffirm those value claims, which, in turn, will influence their future behaviors.

Commitment to Caring

Participants described how being a "good" nurse enabled them to be better family members by improving their ability to listen effectively, to be more understanding and patient, and to be more caring overall. Similarly, having those skills and abilities in one's personal life made it easier to be a "good" nurse. Carter explains how these skills complement his work and family life. He states:

> I think that being a nurse makes me a better father. A better husband. You have to be [able] to learn about compassion to do my job. It makes the transition home easier. You learn how to talk to people, how to understand what they're going through. Sometimes you act like a counselor. That helps me to be more patient when I'm playing with my sons.

In this statement, we see how, for Carter, being a nurse works in conjunction with being a "good" family member. Similarly, Christina replies:

> I think being a mom helps. There are a lot of students, patients who come to the clinic. And they're not feeling well. And they're homesick. I have a daughter in college, too. And I think that helps. I can think about how I would want someone to take care of my daughter at school when she was sick, and then I try to, you know, apply that to my patients.

In these examples, we see how being a "good" nurse (enacting the "good" nurse identity) facilitates a "good" family member (enacting the "good" family member identity), and how a "good" family life facilitates being a "good" nurse.

Teamwork and Critical Thinking

Participants also saw critical thinking and an ability to act as a resource as important to being a "good" nurse and a "good" family member. Nancy explains:

> You need to be able to think on your feet. Things can change like that. One minute everything is quiet and the next there is chaos. … Having that adaptability is important for life in everyday. You have things planned and then something happens. You wake up and your kid is sick, or you're sick, or they tell you that they needed you to bring

something for school. You have to be able to act quickly. I think that I can change to my situations faster and easier because I have to do it every day at work.

Nancy's comment reflects an idea that "good" nurses are adaptable to a variety of situations. They have the ability to quickly take action and make the best of a situation. This quality, as a result, enables them to manage better their family responsibilities, which, like nursing responsibilities, are often unpredictable. In a sense, nurses may be better able to handle these issues when they arise because they have more practice in handling stressful situations.

Participants also saw ways where their personal lives equipped them with critical thinking skills used while working as a nurse. Specifically, several respondents told stories of how being a parent had polished their ability to think quickly. These stories often described situations where individuals were confronted with several competing demands on their attention that all needed their immediate attention. For example, Patrick describes the first week home after the arrival of his third child. He states:

> You know, you always think it will be easier this time around. You're not as worried about doing things right. You know what to expect as far as sleep deprivation goes. But that first week was one of the most challenging experiences of my life. You had the baby crying, another one, she's waking up from the crying and needing your attention, and then James, he wants to help but he's at the stage where his helping makes more work. And Julie, she was still trying to recover. … After surviving that week, nothing at work fazes me. Nothing gets me too excited.

"Good" employees, "good" nurses, and "good" family members are able to handle several projects simultaneously. Jamie explains:

> I have to be very efficient with my personal time because not only do I have my children to take care of, I also have an aging parent. My mom, she needs me to make sure that she's got someone to take her to her appointments, shovel her walk, you know, I have to do a lot of her home upkeep. She can't do laundry because she has a bad back. So I have to take care of her as well. So while I'm thinking of where each kid needs to go, is today soccer practice or piano, I also need to make sure that someone is checking in on my mom.

In these scenarios, Patrick and Jamie explain how coordinating one's personal and family responsibilities has enabled them to be better nurses.

When they cannot do it all, "Good" nurses and "good" family members are able to delegate tasks. Tricia explains how it is important to "know your strengths, what you're good at, and then maybe what you're not so good at." She then also notes that, after recognizing your own weaknesses, "that's where you ask for someone else to help

you out. That's where you delegate, where you act as a manager." This management could include asking a spouse, another family member, or a friend for help.

Lorraine sums up this idea; she states, "…to do a good job whether or not you're at home or at work, you have to work as a team. And you've got to learn to be honest about what you can do with the time you have. And you've got to be able to ask for help." "Good" nurses and "good" family members are able to understand their current situation and use others as resources. Margaret explains:

> I think that a good nurse too is someone who if a question is asked and they don't know the answer they don't make it up. They don't BS the patient. I can't stand that. One who says, "I don't know the answer but I know where to get it. And I'll get you to the right person."

To be "good" employees and family members do not need to do it all. Instead, they must be willing to work as a part of team. "Good" employees do not lie to their patients, their families, or their coworkers. They do not feign skill or knowledge. Honesty is an important part of being a "good" team member, of being a "good" nurse and a "good" family member. The teambuilding skills learned at work may transfer into promoting a better family life, while the coordination skills developed as a family member may make it easier to be a better nurse.

Working as a team also meant that nurses worked a variety of shifts to provide continuous care to their patients; this, in turn, created a non-traditional and often flexible schedule for nurses. This flexibility enhanced nurses' ability to be both "good" nurses as well as "good" family members. As Rose, among others, mentioned, patients often need care every day, twenty-four hours a day. As a result, nurses' schedules' flexibility may make it easier to be a "good" family member. Hannah explains:

> [Being a "good" nurse and having a "good" family life] have [conflicted] at times, but luckily, when my kids were little, when the older ones were growing up, I could work night shifts at the hospital and be home when they were home. So I'd sleep when they were at school, and I'd be awake when they were at home. And then when the younger ones were growing up, then I could be a school nurse and if school got called off because of snow, I would be home with them. Or, during the summer when they had off, I could be home with them.

Working as a part of a team provided Hannah with an opportunity to work a schedule that she felt best enabled her to be "good" family member.

Greta describes a similar experience, she states:

> I think sometimes when you're working and you realize that it's just too much, you want to, like, for me, I worked part time when my kids were little, really little and growing up because I could have worked full time and made more money. But the kids were more important. I wanted to make sure that my kids always knew that I was there for them. So if they had an event like a hockey games, or baseball games, or tennis or golf. Or usually, they did golf by themselves. But any, any hockey game, any tennis match, I was there for them. Any practice they needed to be picked up from, I was there for. I didn't want to be too busy working.

Although they may work non-traditional schedules, "good" nurses may be able to use this schedule flexibility to be "good" family members. In this way, being a team member includes critical thinking, resourcefulness, delegation, and coordination. Participants explained that workgroups and families were teams. These values are important to both an understanding of "good" nurse and "good" family member. As a result, embracing these values, being a team player, makes it easier to bridge the two identities.

Satisfaction

Another area where participants saw the definitions of "good" nurse and "good" family member as overlapping existed in overall job satisfaction. Almost all participants explained that they loved what they do. They describe their work as "interesting," "exciting," "never dull," "challenging," "motivating," with the most commonly used terms to describe their work as "meaningful" and "important." Throughout the interviews, participants cited several frustrating challenges they encountered throughout their work, but said that they "wouldn't have it any other way." Participants described their job satisfaction as positively influencing their personal lives by giving them an opportunity to use their talents and skills in meaningful work.

Irene explains how her work makes her feel as though she is contributing to society in a positive way. She states, "I'd hate myself if I stayed home all day. … I mean, I love my kids, but I wouldn't be happy. I want to do more than just be a stay at home mom." In this statement, Irene indicates that working as a nurse is important in making her feel fulfilled. She continues,

> I love what I do. And, yes, I, I know that it would be a lot easier to stay at home. And I know that we probably could afford it. But I wouldn't be happy, and if I'm not happy, if I don't feel good about myself and my work. I don't think that I make a good mother or a good wife. I love my kids and I want to be a great mom. So I need to work.

In this statement, we can see how being a "good" nurse enables Irene to be a "good" family member. She does not feel she would be a "good" family member without her nursing work. Felicity sees a direct connection. She states:

> Good family usually means a good nurse. If you're happy you're usually a better worker a better nurse. You're not distracted. You're able to focus on your job and what you do and do a good job. You know, if you're a little bit if you leave your house and things aren't so good you come to work and you may be carrying a lot in your mind. And you're more likely to miss things more, not really care as much about what you're doing at work. You have less attention and energy to care about your patients. You have less patience.

These examples represent several of the responses, where participants highlighted the importance of nursing in their work as mothers, wives, and friends. They often noted that satisfaction in your personal and professional life worked in tandem. By doing "meaningful work," participants are able to embrace the values of "good" nurse and "good" family member. In this way, being a "good" nurse facilitates and is facilitated by being a "good" family member.

RQ2: IN WHAT WAYS DO THE MEANINGS FOR "GOOD" EMPLOYEE, "GOOD" NURSE, OR "GOOD" FAMILY MEMBER CONFLICT WITH EACH OTHER?

Although the understanding of what it meant to be a "good" employee, a "good" nurse, and have a "good" family life enhanced each other in some ways, also cited several tensions between these identifications. Again, because participants framed their responses emphasized the centrality of the nursing identity in their responses. In this section, I answer the second research question (RQ2), which asks: *In what ways do the meanings for "good" employee, "good" nurse, or "good" family life challenge or contradict each other?* First, I will discuss the tension between being a "good" employee and a "good" nurse. Second, I will talk about the tension between being a "good" nurse and having a "good" family life.

"Good" Employee Challenging "Good" Nurse

A "good" employee is someone who comes into work on time and consistently performs well. However, participants also indicated a tension between being a "good" employee and a "good" nurse. Specifically, some participants explained that it is possible to be a "good" employee but not a "good" nurse. Lorraine notes,

You can be a great technical nurse, but a very bad employee. Like, you can do a great job when you're here and you're working, but you might not show up on time, or you might call in sick all of the time.

In this statement, Lorraine explains that individuals can have the skill set needed to be "good" nurses; they may simply choose not to use them. Olivia describes a situation where she saw this divide. She states:

I work with some really great people. But every once in a while. You know. You get one that just frustrates you. I used to work with this girl who was a great nurse. She was a great technical nurse, and she was great with patients. But she just couldn't get it together with her personal life. She got married too young. Well, in my opinion she got married too young. Not ready, not enough. Not mature enough. Well, she got married and had kids real young, you know. And then she went through a really bad divorce. Really horrible. And so then she was a single mom. Hard you know. And her kids were calling her at work all of the time. Fighting and screaming at each other. Or she'd always be calling in because one of her kids was sick. So when she was here and was doing her job and her kids weren't calling. Then she was a great nurse. But other times. Her life was a mess. She wasn't a good employee.

In this example, Olivia explains that, at times, nurses have the skills to be "good" nurses but personal situations keep them from being "good" employees and "good" nurses. This example also shows a tension between employee and familial identities. For Olivia's coworker, being a "good" employee hindered her ability to handle her personal problems.

More often, the tension between "good" employee and "good" nurse became known when organizational rules or values prevented nurses from doing "good" work. Diane describes this as a routine tension. She states:

It's a daily thing. And that would be when you have a high patient load, you've got a lot of patients coming through and you want them to all feel comfortable. You want them to all feel like they've had enough time and attention. But you're running from one to the next trying to get your data gathered, your vital signs, your signs and symptoms, that sort of thing. And also working to try to get the things done that the doctors need. What the doctor's need you to do. So they're ready when he walks in the door, or she walks in the door. If you're a patient at the clinic and I bring you back to the room and I take your temperature and your blood pressure and all the statistics that I need from you. Your medications, your symptoms, that sort of thing, what you're experiencing. And trying to make you feel comfortable. Trying to give enough time to feel like you've got enough attention but getting it done so that the doctor can get in. Then I come in and get the blood tests done, any blood work done, any sort of treatments that need to be done. All while trying to get the next patient ready for the doctor to see.

In this example, Diane talks about how a "good" employee is efficient and can see a large volume of patients in a short period. However, a "good" nurse is able to spend more time talking with the patients and making them feel comfortable.

33

"Good" Nurses Break the Rules

A "good" nurse is one who follows organizational rules and policies, particularly those of the team or local workgroup. Irene states, "It's important to follow procedure in our work. It's important to do those things. That's important to being a good nurse. To being a good employee." In this comment, Irene notes that a "good" employee and a "good" nurse is someone who follows the organizational rules and regulations.

While participants understood the importance of following rules, of being "good" employees, they emphasized that a "good" nurse does not do so blindly. Instead, a "good" nurse knows when to follow the rules, when to bend the rules, and when to break the rules. Becca explains, "I think that's the thing, that's what separates the good nurses, the ones that do a decent job from the really great ones. The good ones follow the rules, but the great ones, well, they make life interesting." Therefore, while most nurses will normally follow official rules and procedures, a "good" or "great" (to use Becca's distinction) nurse assesses each situation individually. Specifically, "good" nurses may break the rules and challenge what it means to be a "good" employee by rejecting the organizational value of financial efficiency and working as patient advocates.

Financial Inefficiency

Participants highlighted a tension between being a "good" employee, which often represented being the most financially efficient, and being a "good" nurse, which represented doing what was in the best interest of the patient. Simply put, being a "good" nurse was not always the most cost effective option. Participants explained that, when forced to choose between being a cost-effective "good" employee and a "good" nurse, the latter always prevailed. For example, Allison states:

> Oh yeah. I mean, there are always times when there is so much coming at you that you just can't handle it all at the same time. I mean, there's always those days. You know, this ones sick or this one's dying and there is only so much that you can do as an individual or even as a team. So, a few years ago they wanted to make cuts to save money. They wanted us to just do the technical parts of the job. You know, giving out medication, turning patients, checking on patients. And they cut everyone's hours. But you can't do that to the patients. They need you to help them out. That's why they're in a nursing home, you know. They often don't have anyone else. Some of them don't have family nearby. So we stayed and worked over time. We still needed to take care of our residents. We couldn't just do the technical things. Our job is to take care of the residents and give them what they need. And they need that personal caring. We weren't going to stop that. So it didn't really work, you know. Cutting our hours. Because we just stayed

34

on overtime and they lost more money. So now I think they know that we can't just do the minimal amount of care for our residents.

In this example, Allison shows how she could not simultaneously be a "good" employee by working fewer hours and be a "good" nurse by providing care to her patients. She, with all of the other participants, expressed that being a "good" nurse was a far greater priority than being a "good" employee.

Patient Advocate

Additionally, one of the greatest sources of tensions between "good" employee and "good" nurse that participants cited occurred when following official polices and being "good" employees prevented them from providing their patients with the best possible care. To respond to these tensions, several participants explained that they worked to find loopholes within the system or, at times, overtly broke the rules. Brianna describes a situation where one of her patients, an elderly man, came into the clinic because his Medicaid prescription plan no longer covered his medication. She explains:

> It's really hard when things like that happen. Because his medication had been working, but his formulary wouldn't cover it. And it's hard because the other medications had worked, but none had worked as well as this one. But his formulary wouldn't cover it. … But I looked it up. … And he could get it covered by Medicaid if it was for a different disease process. So I told the physician and he agreed to write that it was for the disease process that would allow him to get his same medication.

In this response, we see how Brianna worked within the system, following the drugs approved by the formulary, but encouraged the physician to write a prescription for another, related ailment that included the patient's drug as a part of his formulary. Working within the system, yet challenging what it means to be a "good" employee is often important for nurses' daily work.

Others said they felt that a "good" employee is to defer to a physician or, in, Jamie's words "be quiet and do as you're told." This description contrasted dramatically from what they saw as the role of a "good" nurse. Debbie continues, "It's my job to fight for my patients. They need someone in their corner, and, I'm, I'm their advocate." She states:

> A long time ago, when I first started. I worked in a really conservative town where everyone knew everyone's business. … One day a young woman came in, she was in college and home over Christmas break. Well, she'd been having sex but didn't want to tell her physician. He was a member of her church and, you know. … So, after he left, she told me that she wanted to find out about birth control. What her options were. So

this nurse called a friend at Planned Parenthood, explained the situation, and set up an appointment for her so she could get some information. It's my job as a nurse to find out what's really going on and make sure that I do whatever I can for my patients.

Similarly, Kathrine remarks, "If a patient comes in with her mother or her boyfriend, and they're causing problems, creating stress, stress that we don't need. I'll tell them to leave the room. Sometimes a patient can't stand up to them, so then it's on me." In this way, if being a "good" employee at a particular health service organization requires nurses to "be quiet and do as your told," there will be a tension between being a "good" nurse and a "good employee." When embracing organizational values (e.g., cost effectiveness) means stepping away from professional values (commitment to patient), it can be extremely difficult to be both a "good" employee and a "good" nurse.

"Good" Nurse Challenging "Good" Family Member

Although participants highlighted several areas where being a "good" nurse complimented what it meant to have a "good" family life (and vice versa), they also indicated several ways in which these ideas challenged each other. Specifically, the need to constantly care and adapt to a non-traditional schedule were described as two areas where being a "good" nurse challenged being a "good" family member. Interestingly, these were the same areas where participants saw a positive overlap between "good" nurse and "good" family life.

Constant Caring

While several participants highlighted how being a "good" nurse helped them to be a more caring and compassionate person with their familial relationships, participants also noted that the commitment to caring (both at home and at work) was emotionally draining. Brianna explains,

> … if you're working a 12-hour shift, it is constant. It's constant give. Whether you're giving to the patient, whether you're giving to the families, whether you're giving to the physicians, whether you're giving to your coworkers. I mean it's just constant give. There's absolutely. You don't get to leave and go out for a leisurely lunch at Arriba. Or you know a quick run. I mean, you're tied to a pager. You're really tied to your to your patients. There's really no break. There's absolutely no break. There's really no break in that 12-hour shift.

The need to give emotionally, to walk patients and their families through emotional experiences for twelve hours a day proved to be a daunting task for many nurses.

Participants often compared nursing's emotional work to other professions. For them, the need to care constantly made it more difficult to balance "good" nurse with "good" family life at times. Unlike other professions, which may have the same long hours or physical demands, the emotional component placed nursing in a distinct arena. Nichole provides a breakdown; she states:

> I think the one thing though. Is my husband works in construction. And it's not. They're long days, because they're physical days. And they're not emotional. A nurse's day is an emotional day. Whether you find out your patient needs bypass surgery, and the daughter's crying, and the wife's crying, and you're comforting, and you're... And that's a daily occurrence around here. So the emotions are more spent at the end of the day. And it's a very physical job. …So they're physical and they're emotional. And that's very draining. There's not a lot left at the end of the day to give. And I think that when you have kids, I think your husband is the one who gets the short-end of the stick. I mean, they "that's it" there's just nothing left. So I think in that way nursing is definitely more draining than most. Than other professions.

They explained that, unlike other professions, which may have the same long hours or physical demands, the emotional component makes being both a "good" nurse and a "good" family member distinctly challenging.

Feeling powerless increased the emotional exhaustion, which made it more difficult to be both "good" nurses and "good" family members. Participants described how at times they had to watch as a patient suffered. They often felt powerless because they could not take away the pain; in fact, watching a patient physically suffer was described as being more emotionally taxing than having a patient die. Wendy states:

> Oh, everyone gets attached to your patients. I've worked in nursing homes since I got my license. And you get attached to your patients. Some of them are so sweet and you don't ever forget them. And sometimes you watch them suffer while they're dying and at the end when they go it's like a blessing. They can just go finally. And you feel better that you're gone. Instead of watching them suffer. And it's harder to watch the suffering because you see them every day. They don't just come in and see you for one visit. You see them and build a relationship with them. And it's really hard when your favorite resident is suffering. It's also hard when they go. But you know that it's better because they're not suffering.

Wendy continues by saying that it was difficult to leave these emotional experiences at work. Yet, she explains that her experience is something her family members cannot understand and, subsequently, they cannot always offer her the kind of emotional support she wants or needs. She says:

> Sometimes it's so hard. If you've been watching someone suffer all day. And you see them in pain, and it's so hard to watch. And then you come home and the house is a mess.

You don't have any patience. You just snap. And your family doesn't deserve that. But they don't know what you're going through.

For Wendy, this emotional drain, at times, inhibits her ability to have a "good" family life by shortening her patience and making her more easily agitated. As a result, she feels as though she is not able to interact in a way that she would like with her loved ones.

Schedule

Although the flexible schedule helped some participants to be both "good" nurses and "good" family members, others explained how a nurse's schedule, specifically the overnight schedule, made it more difficult to embrace both identities. Nancy offers this advice for those considering being a nurse, she states:

It's important to know that you *will* be tired. Exhausted. It's tiring. You don't sleep a lot. You work all night and then you're somewhat awake during the day. And you want to be with your family and you want to do things. So to do them, you just have to be willing to push through the exhaustion.

Although the schedule allows nurses to work alternate days/times, participants also explained how this was challenging because their families did not live on the same time schedule. As a result, nurses are often left to choose to miss out on a family activity or, as Nancy stated, "push through the exhaustion." Specifically, several participants noted that they opted for a particular schedule in an effort to balance childcare needs (e.g., nurse stays at home during the day and works at night while spouse is at work during the day and home at night). Yet this also created challenges when a participant wanted to do something with the "whole family" (nurse, spouse, and children). Greta explains this tension, "…my husband and I are like a relay team. We're always passing the baton. But we rarely spend time just the two of us. And it's hard to make a relationship a good marriage without that time…"

Most participants emphasized how their family had been very forgiving of their alternative schedules. Yet, it became more challenging to be a "good" family member, who is involved in the lives of one's children. Allison explains, "The worst is conferences. You know, parent-teacher conferences. They always want you to come in at 3:00, after school. But for me, that's like you coming in for a meeting at 3:00 in the morning." Long hours and overnight shifts do not always coincide with the responsibilities or obligations important to being a "good" family member.

This tension was not limited to overnight nurses. Greta offers this advice for those considering nursing as a profession. She states, "If you don't want to work weekends. And you don't want to miss certain things in your life. And if you just want a 9-5 and you want to come home on Fridays and not worry about your job for the weekend, don't be a nurse." In this advice, we see an expectation of nurses to "miss certain things." This, in turn, may make it more difficult to be both a "good" nurse and a "good" family member.

RQ3: HOW DO NURSES LEARN WHAT IT MEANS TO BE A "GOOD" EMPLOYEE, A "GOOD" NURSE, OR A "GOOD" FAMILY MEMBER?

Nurses' understanding of what it means to be a "good" employee, to be a "good" nurse, and to have a "good" family life is complex and complicated. Throughout the interviews, participants highlighted the ways in which they used the members of their peer groups (family and work team) as models for these ideas. In this section, I answer the third research question (RQ3), which asks: *How do nurses learn what it means to be a "good" employee, to be a "good" nurse, or to have a "good" family life*. First, I will discuss the ways in which participants' workgroup or team influenced their understanding of what it means to be a "good" employee and a "good" nurse. Second, I will describe how participants' families influenced their understandings of "good" employee and "good" family life.

Work Group

Another theme that can be pulled from the interview responses is the role of the peer group in identity construction. The members of one's work group played a key role in developing their understanding of what it meant to be a "good" nurse. Emma states, "I think a lot of it comes from watching other people. You see people that you think are good nurses and you try to be more like them. But you also look at people that are bad nurses and you learn to be different. You learn from everyone." However, the peer group did not simply inject participants with a specific frame of reference. Instead, participants closely watched their peers, evaluated which behaviors they saw as desirable, and then interpreted them into their own lives.

Participants described their coworkers as the greatest source of information from which they gleaned what it meant to be a "good" nurse. Teamwork is an integral component of nursing, as nurses must coordinate their actions to complete their work

tasks. For example, several of the participants who worked at nursing homes described how they often had to work as a team to move patients. Here, they physically had to work in tandem, but participants also described how they had to coordinate their individual activities to fit the team goal as well. Because teamwork played such an important role in participants' daily lives, they emphasized that it was important to be a "good" nurse to contribute to the team.

As a team, participants explained how nurses create their own rules for what is acceptable, what is a "good" nurse or a "good" employee. Nancy explains how official organizational policies can be vague; as a result, it is up to the employee's team to decide how these will be constructed. She states, "They say, 'Complete your charts in a timely fashion,' but we know that if you get it done by the next day or so that's good." In this statement, we can see how the official organizational policy was somewhat vague about how quickly charts needed to be completed, yet Nancy explains that for her team completing them within a day or two is acceptable.

Several participants explained how they often work as an autonomous work unit, without any direct supervision from the health service organization's administrators or managers. This autonomy, for some workgroups, enables them to be flexible about policies. Jalyn explains, "…if you need to take some time off, we cover for you. Someone will cover for you." For Jalyn, her workgroup saw being a "good" employee and being a "good nurse" as someone who offered assistance and worked as a part of a team. She continued by explaining how covering another nurse's shift was never discussed as a team norm; rather, she saw others taking over at times and replicated the behavior.

To be a part of a team, it is important to be a "good" nurse. Furthermore, participants repeated that nurses could not learn all they need to know through formal education. Christina states,

> You have to be able to work well with others and be a people person. You know you need to have a basic knowledge of your, your profession. When you go to nurses' training, they teach you what they call the foundation of what you need to know and then you build on that as you go throughout your career. And so with each job that you work, you gather new information from it.

As Margaret says, "There's just no way [to learn everything from formal education]." As a result, nurses must look to their peers as models. In fact, several participants explained

how when they first started nursing, they were often paired up with another "good" nurse. Through these pairings and on-the job training, participants often cited examples where a "bad" employee was described. Jalyn describes how she has learned what it means to be a "good" employee and a "good" nurse. She states:

> Well just like being at work and seeing all of the different people. You know definitely, there are people who are probably should choose a different, you know, I think there are people who just do what they do and maybe if there were okay at one point but maybe should you know they've gotten older and maybe should consider another job. And then there are some that are so awesome and it's definitely what they were meant to do. Through the experience you see all different sorts of work ethics. And just by being on the job and seeing people and seeing how people work and interact that is definitely one of the, you learn so much from other people. You learn both about how to be an employee and you learn about the type of nurse you want to be. Because you know people talk about the people that aren't good. And you don't want to be one of those people.

In this description, we can see how the role of the peer group influences nurses' daily enactments of a "good" nurse or a "good" employee. In addition to being committed to one's position, a nurse also does not want to be labeled one of "those people," one of those who "probably should choose a different [career]."

Family

Participants' immediate workgroups were not the only form of social persuasion. Many of them indicated that they learned what it meant to be a "good" employee from their parents. For example, Paula responds, "…I learned how to work and how to work hard. I learned a lot about my work ethic from my parents. They probably taught me the most about what it means to be a good employee." Interestingly, no participants cited their current employer as factor in their understanding of what it means to be a "good" employee.

Similarly, watching the ways in which their parents managed responsibilities influenced the ways they now managed these responsibilities. Irene explains:

> When I was growing up both of my parents worked. I grew up on the resort. So, for me, I was used to a working mom. It was different because summers were extremely busy and then it was much quieter in the winter with ice fishing. For me summers are when it's a little easier. But it was also different because we all worked together. Even when my parents were working, they could still be with us kids. I can't take my kids to work. It's a different type of work.

For Irene, the idea of a dual-career family was familiar; yet, her parents' situation differs from her current situation. She describes how she selects those ideas from her upbringing

that are "universal" and adheres to those, while she understands nursing can be different from owning a resort.

In regards to managing family and work responsibilities, participants explained that they expected it to be difficult. Rose states,

> I think I always knew this is the way it would be. I came from a working family. … We had a big family. I mean, my work ethic came from them. I mean I, I knew what a working parent was. I knew what a latchkey child was. I didn't have the expectation that it was going to be all that different for me.

In this description, Rose explains how she expected that there would be challenges to be a nurse and raising a family.

In addition to gleaning information about work-family balance from one's parents and family of origin, some participants also described other family members who influenced their understanding of what it meant to be a "good" family member. For example, Greta describes how her relationship with her in-laws has dramatically influenced her understanding of what it means to be a "good" family member. She explains, "Todd's family is so close. Mine was never like that, supportive, supporting each other. I see his parents and they're so great. That's the kind of couple I want to be. That's what I want. I want to grow old like that." Greta continues by explaining how while growing up, her parents relationship was cold and distant, more like a business partnership than a romantic relationship. Her husband's parents relationship represented what she saw as an ideal marriage. To be a "good" family member, to be a good spouse, she worked to emulate her spouse's parents' relationship.

In these ways, it is interesting to note the importance of the peer group in nurses' understanding of what it means to be a "good" employee, a "good" nurse, and a "good" family member. Through interactions with peers, they learn what it means to be "good." Specifically, they want to avoid being a "bad" nurse.

SUMMARY

In this chapter, I have presented my results and worked to answer my three research questions. Through an analysis of the data, we can see how the meaning for "good" employee, "good" nurse, and "good" family member are both complementary and contradictory. Furthermore, the participants' responses highlighted the importance of the

peer group as important in their development of what it meant to be a "good" employee, "good" nurse, and "good" family member.

It is important for both "good" nurses and "good" employees to be team players, to model healthy behaviors, and to demonstrate commitment to patient care. When health service organizations emphasize these values and characteristics, it becomes easier for nurses to be "good" nurses and "good" employees. For example, being a "good" nurse, being dedicated to patient care, may do better work. As a result, being a "good" nurse enabled one to be a "good" employee, one who produces high quality work. Similarly, being a "good" employee, being dependable and on time, may facilitate being a "good" nurse. "Good" nurses who are on time will have more time to focus on patient care.

In addition, the meanings for "good" employee and "good" family member may also complement each other. In particular, when nurses are caring, dedicated team members who enjoy their jobs, they may find it easier to be "good" family members. In turn, when individuals are able to be caring at home and are happy with their personal lives, they are more likely to be "good" nurses. For example, individuals who are kind and patient with their children may be more adept at expressing compassion and empathy for a sick patient. Similarly, nurses who are able to manage stressful situations at work may be able to manage stressful situations at home.

While the meanings for "good" employee, "good" nurse, and "good" family member are complementary in several areas, they also conflict with each other at times. Specifically, when being a "good" employee does not reflect the values of "good" nursing, nurses may elect to break rules. In this way, commitment to the patient, more than financial efficiency or other possible organizational values, supersedes being a "good" employee.

Additionally, the meanings for "good" nurse and "good" family member may also contradict each other. In particular, when organizational and professional values are placed at extremes, nurses may find it difficult to meet both demands. For example, while it is important for "good" nurses and "good" family members to be caring, the expectation to give constantly, at work and at home, can be particularly draining. After an emotionally exhausting day at work, nurses may struggle to be "good" family members, who were emotionally available.

One's understanding of what it means to be a "good" employee, a "good" nurse, or a "good" family member can come from a variety of sources, such as media, education, organizational training, among others. Participants in this study emphasized the ways in which members of their peer groups (family and work team) served as models. Specifically, nurses observed others and reflected on their childhood as they created an understanding of "good" employee and "good" family member. In addition, they aspired to resemble individuals they saw as "good" nurses and worked to avoid being designated as less committed, less caring, or a "bad" nurse.

CHAPTER FIVE: DISCUSSION

OVERVIEW

In the preceding chapter (Chapter 4), I presented the results of this study and used the findings to answer the following research questions.

RQ1: In what ways do the meanings for "good" employee, "good" nurse, or "good" family life complement each other?

RQ2: In what ways do the meanings for "good" employee, "good" nurse, or "good" family life challenge or contradict each other?

RQ3: How do nurses learn what it means to be a "good" employee, "good" nurse, or to have "good" family life?

In this chapter (Chapter 5), I will describe the theoretical implications this study provides for the study of organizational communication. I will conclude this chapter by highlighting some of the practical implications of this study for nurses and health service organizations.

IMPLICATIONS

Organizational life is wrought with conflict and contradictions (Ashcraft & Trethewey, 2004). This is particularly salient when discussing multiple, and possibly conflicting identities, such as organizational identity, professional identity, and familial identity (Larson & Pepper, 2003; Scott et al., 1998). This study reinforces and extends previous research on work-family tensions by positioning work and family not as two realms, but as two distinct identities. Furthermore, it reinforces and extends previous identity research by highlighting the interaction between professional and organizational identities. The study also provides several practical implications for nurses, health service organizations, and other organizations or individuals who are interested in work-family issues.

THEORETICAL IMPLICATIONS

This study can offer two primary theoretical implications to the study of organizational communication. First, this study reaffirms and extends work-family research by situating work and family as complementary and competing identities. Second, this study reinforces and extends research on organizational identification by

highlighting communication-identity connection and the complexity of multiple identities.

Work-Family as Issues of Identity

To begin, this study offers a unique look at work-family tensions by framing these tensions as identities. Situating these tensions as identity issues both reaffirms and extends work-family research. Much of the existing research has framed work-family tensions as issues of boundary management. Problems are said to arise when responsibilities and stresses from one area spill over into another (Burke & Greenglass, 1987; Piotrkowski, 1979). Specifically, researchers have highlighted the negative effects of poor boundary management in terms of role strain, psychological distress, and physical ailments, such as sleeplessness (Frone, Russell, & Cooper, 1991). To explore these issues, researchers have looked at individual behaviors (Hill, Hawkins, & Miller, Hochschild, 1997; Medved, 2004; Nippert-Eng, 1995), spousal interactions (Golden, 2002), and organizational policies (Thompason, Beauvais, & Lyness, 1999) and placed the boundary management strategies and outcomes on an integration-segmentation continuum. Integration strategies, such as on-site daycare promote physical integration of work and family spheres. This approach tends to highlight the ways in which work and family can work together. Segmentation, strategies, such as flextime, retain an emphasis on separate areas but attempt to facilitate work-family balance by providing flexibility. This perspective often assumes that blending work and family activities, which challenge each other, creates more stress. As a result, the boundaries between work and family should be clearly defined.

This study reinforces existing work-family research by noting the ways in which being a "good" employee, a "good" nurse, and a "good" family member are constrained by external factors. For example, considerable research (e.g., Greenhaus & Beautell, 1985) has suggested that time, or lack thereof, is a contributing factor in work-family tensions. Throughout their responses, participants described how time affected the ways in which they embodied "good" employee, "good" nurse, and "good" family member. There often was not enough time to spend with patients and still keep up with administrative responsibilities (e.g., charts). Long shifts at times made it difficult to be a "good" family member. In this way, we can see how external influences, such as time,

affect the ways in which individuals manage work-family tensions, what it means to be a "good" employee, a "good" nurse, and a "good" family member.

This study takes neither an integrating nor a segmenting approach to examining work-family issues. Instead, by framing work and family as identities, we can see the ways in which they are simultaneously complementary and conflicting. For example, empathy and caring are integral components of being a "good" nurse as well as being a "good" family member. Being a "good" nurse facilitates being a "good" family member, and vice versa. However, caring in both capacities also creates strain by focusing on constant caring.

Furthermore, much of the existing research has examined work-family tensions in terms of organizational roles and familial roles. This study complicates the work-family discussion by adding professional identification in addition to organizational and familial identities. This study examined the interplay between "good" employee, "good" nurse, and "good" family member. Work-family research has often described work responsibilities in terms of employer demands, rather than professional identity. In this study, participants emphasized the importance of being a "good" nurse above other identities, such as "good" employee. Therefore, it seems likely that, even in the presence of organizational policies aimed at facilitating work-family balance, professional identification may dictate their use in situ. For example, when organizational policies encourage working fewer hours by reducing the amount of time spent with each individual patient. "good" nurses' commitment to patients may prevent them from using policies that keeps them from embracing the "good" nurse identity.

Communication-Identity Relationship

Although current discussions often frame identity and identifications in terms of "multiple identities," this study reaffirms the relationship between communication and identity and suggests that the boundaries between identities are often blurred. This, in turn, has implications for both our understanding of multiple identities and identity negotiation.

First, this study takes a structurational model of organizational communication (Scott, Corman, & Cheney, 1998). Within this framework, individuals' sense of identity influences their actions, which, in turn, help to create and recreate their sense of identity.

Through communication patterns, organizational members create both structure and agency. In this sense, identification is both a process and a product, where individuals create and change rules of behavior and (re)define the values that guide behavior. These patterns are cyclical, as identification and identities create, maintain, and transform each other (Larson & Pepper, 2003; Scott, Corman, & Cheney, 1998). Moreover, individuals do not have one "true" identity; rather, they must make sense of and manage identity tensions.

This study reaffirms the mutually constitutive relationship between communication and identification by providing empirical evidence of the ways in which nurses make sense of and manage what it means to be a "good" employee, a "good" nurse, and someone with a "good" family life. By asking participants to make sense of the identity tensions, they experienced through "interview talk" (Larson & Pepper, 2003), one can see the process of identification in addition to the product, identity (Scott, Corman, & Cheney, 1998).

Throughout this study, we can see how organizational members use communication to reinforce and reaffirm identities. For example, as participants told and retold stories about "bad" nurses, where they highlighted specific character traits and behaviors, nurses established those traits and behaviors as important. For example, a "good" nurse is to be caring; this term was used throughout every description of a "good" nurse.

In this study, we can also see how organizational members can use communication patterns to actively restructure their identities. For example, when their own sense of what it meant to be a "good" nurse did not fit with others' understanding of "good" nursing (being a "good" employee), they altered their communication patterns to change this quality.

By providing empirical data that reaffirms the ways in which communication creates and is (re)created by identity, this study supports a structurational model of identification. Always in flux, ever complex, and frequently conflicting, identities must be created, maintained, and challenged through everyday interaction.

Multiple Identities

Existing research often situates individuals' understanding of a stable identity as a negotiation of multiple identities. Miller et al. (1996) argue that behavioral decisions, such as the decision to take maternity leave, are a form of identity negotiation. Here, pregnant employees often negotiate what it means to be "good" employee and "good" family member.

Ingrained in discussions of managing multiple identities is the notion that each identity is a distinct identity. However, Tracy and Trethewey (2005) note that, "the self is seen as neither fixed nor essential, but instead, as the product or an effect of competing, fragmentary, and contradictory discourses" (p. 168). They explain that these multiple identities do not represent a dichotomy between real and fake self; rather, individuals must negotiate these identities. This study reinforces Tracy and Trethewey's (2005) argument that organizational life is tension-filled and wrought with competing identities as it shows how nurses struggle daily to negotiate being a "good" employee, a "good" nurse, and a "good" family member among a variety of other identities. For example, good nurses break and follow rules. They are committed team members who are willing to give 100 percent to their workgroup, yet they also are dedicated family members who want to give as much as possible to their family.

This study extends this discussion by showing how the boundaries that define identities are often blurred. Again, what it means to be a "good" employee, a "good" nurse, and a "good" family member is "neither fixed nor essential" (Tracy & Trethewey, 2005). This study reinforces Tracy and Trethewey's conceptualization of identity as crystallized, with individuals like prisms, refracting and reflecting various identities. Rather than individuals entering "work" and "family" realms as one "true" person, they embrace and resist various identities within these roles. For example, for nurses, empathy is not limited to family life. Furthermore, many indicated that it could be difficult to embrace on identity without acknowledging another. For example, being a "good" nurse at times was synonymous with being a "good" employee.

In addition to being the product of competing discourses, identity is also the product of complementary discourses. These complementary discourses often work to reaffirm particular actions as preferred, such as when being a team member is valued

both in being a "good" employee and a "good" family member. In this way, embracing a particular identity may facilitate another identification. For example, when being a "good" nurse makes it easier to be a "good" family member.

This study offers two primary theoretical implications to the study of organizational communication. It reinforces and extends existing research by framing work-family tensions as identity-tensions. This, in turn, reinforces our understanding of the ways in which identities may simultaneously facilitate and hinder work-family tensions. Second, this study reinforces the connection between communication and identity and highlights the messiness of identity, as identities are often blurred and fragmented.

PRACTICAL IMPLICATIONS

In addition to supporting and extending previous research, this study has several practical implications. Specifically, this study's results may have implications for retaining quality nurses. Several organizations have incorporated work-family policies in an effort to recruit and retain high-quality employees. Employee retention is particularly important in the healthcare industry, where poor employee retention will not only create financial problems for the organization, but has the potential to result in a loss of life. In fact, Aiken (2002) argues that, "failure to retain nurses contributes to avoidable patient deaths." Furthermore, although nurses learn many of the skills necessary to do their job during schooling, time spent in a work environment and practice increase accuracy and efficiency. Throughout the interviews in this study, participants explained that it was impossible to learn everything during formal nursing education. Instead, they emphasized the importance of on-the-job training. Put simply, nurses with more experience were described as more accurate, more efficient, and possessing a greater understanding of various disease processes. As a result, health service organizations likely will want to keep many experienced members, including nurses, on staff.

While it appears to be the best interest of patients and health service organizations to retain qualified nurses, it is easier said than done. To begin, the very nature of nursing work is emotionally charged, intense, and fast-paced. Coupled with long shifts, nursing can result in professional burnout (Cordes & Doherty, 1993). As hospitals and other healthcare facilities increase workloads, job dissatisfaction and burnout often lead to high

rate of voluntary turnover, which only exacerbates the problem as health care organizations are left understaffed (Vahey, Aiken, Slone, Clarke, & Vargas, 2004).

Although burnout and turnover are common in a variety of professions, they are primed to be particularly problematic in health service organizations as Americans age and require more medical care. A common theme throughout academic and professional nursing literature is the impending nursing shortage. Current estimates predict that, by the year 2020, the United States will have a shortage of 340,000 registered nurses (Auerbach, 2007) or more than one million nurses overall (HRSA, 2006). As a result, it is especially important for health service organizations to consider programs and policies that reduce burnout and voluntary turnover.

As many of the descriptions of a "good" nurse emphasized giving all of oneself to patients, health service organizations as well as nursing educators, can work to challenge the complete selflessness quality emphasized as a part of "good" nursing. For example, health service organizations can work to have a sufficient number of qualified staff members so that nurses are able to provide high quality care (a criteria of "good" nursing), while possibly reducing the likelihood of burnout. If being a "good" nurse does not require complete selflessness, complete emotional involvement and dedication, it may reduce the amount of emotional exhaustion. Burnout and exhaustion may also be exacerbated by hierarchies that devalue nursing work. Health service organizations may work to implement strategies to demonstrate their appreciation for nurses.

In an effort to reduce some of burnouts contributing factors, healthcare organizations may elect to create policies and programs aimed at promoting work-family balance. Several of this study's participants noted the importance of lived experience in their training. In fact, several of them expressed that they appreciated the opportunity to voice their opinions on work-family tensions in the nursing field. Throughout their responses, participants demonstrated ways in which work and family, when framed as identity issues, are both complementary and contradictory. Participants who offered their feedback during member checks explained that health care administrators often created work-family policies and programs without consulting nurses. As a result, these policies and procedures did not always work for nurses. Specifically, their identification with the role of nurse superseded their use of many of these policies and procedures. As a result,

this study provides advice for health service organizations wishing to retain and recruit employees through work-family policies and programs. Before creating such programs, they should look to see how they fit within the nurse identity framework. For example, while completing member checks, several nursing home nurses emphasized the perceived inefficiency of various work-family training programs and policies. In particular, a policy that prohibited overtime was ignored when it prevented nurses from spending time to listen to patients' concerns. This, in turn, increased the strain between being a "good" employee and a "good" nurse instead of alleviating work-family tensions as it had originally been designed to do. By creating policies that enable nurses to be "good" nurses while still providing assistance for work-family balance, organizational members may be more likely to use and benefit from these policies.

The importance of the nursing identity was reflected throughout participants' responses. Being a "good" nurse appeared to be an integral component of their daily experience. Furthermore, they highlighted the ways in which being a "good" nurse both facilitated and hindered their ability to be a "good" family member. As a result, health service organizations may find it beneficial to create programs that highlight the ways in which "good" employee, "good" nurse, and "good" family member overlap. For example, work-family programs can show the ways in which time management skills used at work can also be applied at home. Similarly, delegation skills used at home can be applied at work. In this way, health service organizations and nursing educators may consider the ways in which they can highlight the ways in which work and family can facilitate each other. Yet, recalling the tensions created by constant caring (caring at home and at work), they must do so with caution.

Additionally, because participants identified so strongly with "good" nurse, it would be prudent to understand the professional identity in terms of work-family tension management. This professional identity is learned through a variety of social interactions teachers, coworkers, mentors, for example. Furthermore, because the professional identity held more prominence than organizational identity for this study's participants, it may be fruitful to begin work-family discussions before nurses enter the workforce. Beginning these discussions throughout nurses' education may encourage the use of

policies or provide insights into identity management techniques that are less likely to result in burnout.

In conclusion, this study both supports and extends existing research as well as presents practical implications for retaining quality nurses by reducing burnout and facilitating work-family balance.

LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

Although this study offers theoretical implications to the study of organizational communication and work-family research by situating work and family as complementary and competing identities and presents practical implications for nurses and work-family tensions, it also presents a few limitations. In particular, the current study presents limitations in terms of gender and family structure.

First, the current study's participants included an overwhelming majority of women. While this represents the gender breakdown of the nursing profession, it does not allow a researcher to draw comparisons between men and women. Although the responses of the male nurses in this study mirrored many of the female participants' responses, this may not adequately represent the majority of male nurses.

In addition, although it was not identified as criteria for participation, all participants had at least one child living at home. However, work-family tensions are not limited to individuals with children. The experience and management of such tensions may be different for nurses with other family responsibilities (e.g., single, married, no children, adult children). Furthermore, this study did not specifically ask participants about their current family of origin makeup, therefore, it is impossible to look at and compare the ways in which different familial structures influence the enactment of "good" employee, "good" nurse, and "good" family member.

The current study also posits several areas for future research, both quantitative and qualitative. To begin, this study identifies several ways in which the meanings for "good" employee, "good" nurse, and "good" family member are both complementary and contradictory. Future research could take these themes and categories and work to quantify the extent to which they complement or contradict each other. For example, the current study's participants described a "good" nurse as someone as caring, a team player, adaptable, among other things. Future research could work to assess the relative

importance of each of these qualities (e.g., is it more important to be caring or to be a team player?).

The current study could also be extended through qualitative investigations. Although this study investigated the ways in which organizational ("good" employee), professional ("good" nurse), and familial ("good" family member) identities influenced work-family tensions, there are a multitude of other, potentially competing and complementary identities, that may also influence the interplay of work and family. For example, future research could examine the ways in which religious identity, union identity, or gendered identity also influence work-family issues. In particular, it may be especially beneficial to look at the ways in which team or workgroup identity influences work-family balance.

SUMMARY

To review, this study used qualitative interviews to describe nurses' understandings of "good" employee, "good" nurse, and "good" family member. By positioning work and family not as spheres with discrete boundaries but as multiple identities, this study demonstrates the ways in which "good" employee, "good" nurse, and "good" family member can be complementary, contradictory, even at the same time. Specifically, this study has examined interplay between organizational, professional, and familial identity in nurses. This study offers theoretical and practical applications. Future research may consider the ways other identities (e.g., religious, gender) influence the negotiation of work-family tensions.

In addition, this study reinforces and supports the structurational model of identity and identification. Through their interactions with peers, nurses created meanings for "good" employee, "good" nurse, and "good" family member. Their identification with each role influenced their behaviors and decision-making processes. Specifically, this study shows how, for nurses, professional identity may often trump organizational identity, as "good" nurses elect to break the rules if they see it as in the best interest of the patients. Furthermore, this study reinforces the complex, fragmentary nature of identity. There is not one "true" identity; instead, individuals' communicative behaviors and identity are mutually created and recreated through their interactions.

Finally, this study also presents some practical implications for health service organizations and the nursing profession. In particular, health service organizations and nursing education can use the role of professional identity in an effort to reduce burnout and voluntary turnover. Specifically, they may choose to challenge the selflessness or expectation of constant care, constant emotional availability. Modifying the values that define a 'good" nurse, may encourage the use of programs or policies aimed at reducing burnout. Additionally, health service organizations may find it beneficial to work with nurses to create work-family policies that fit the unique needs of nurses rather than superimposing existing policies.

REFERENCES

American Academy of Family Physicians. (2007). Interventions for child health and parenting practices. Retrieved February 4, 2007, from http://www.aafp.org

American Nurses Association (2006). *The Florence Nightingale Pledge*. Retrieved November 10, 2006, from http://www.nursingworld.org/about/PLEDGE.HTM.

Anderson, C. A. (1999). The critical path to leadership development—The student's perspective. In C. A. Fetters Anderson (Ed.), *Nursing student to nursing leader* (pp.2-15). Albany, NY: Delmar Publishers.

Barker, J. R. (1990). *The discipline of teamwork*. Thousand Oaks, CA: Sage.

Bastable, S. B. (Ed.). (2003). *Nurse as educator: Principles of teaching and learning for nursing practice* (2nd ed.), Boston: Jones and Bartlett Publishers.

Bullis, C. A., & Tompkins, P. K. (1989). The Forest Ranger Revisited: A study of control practices and identification. *Communication Monographs, 56*, 287-306.

Bureau of Labor Statistics (2005). *Demographic characteristics of the labor force*. Washington, CD: U. S. Government Printing Office.

Bureau of Labor Statistics (2006). *Occupational Outlook Handbook, 2006-207 Edition*, Registered Nurses. Washington, DC: U.S. Government Printing Office.

DiSanza, J. R., & Bullis, C. (1999). Everybody identifies with Smokey the Bear: Employee Responses to newsletter identification inducements at the U.S. Forest Service. *Management Communication Quarterly, 12*, 347-399.

Dock, L., & Stewart, I. (1937). *A short history of nursing* (3rd ed.), New York: Putnam's Sons.

Dolan, J. A., Fitzpatrick, M. L., Hermann, E. K. (1983). *Nursing in society: A historical perspective* (15th ed.). Philadelphia, PA: Saunders.

Dossey, B. M. (2000). *Florence Nightingale: Mystic, visionary, healer*. Springhouse, PA: Springhouse.

Evers, G. C. M. (2001). Naming nursing: Evidence-based nursing. *Nursing Diagnosis, 12(4)*, 137-142.

Fetters Anderson, C. A. (Ed.). (19990). *Nursing student to nursing leader: The critical path to leadership development*. Albany, NY: Delmar Publishers.

Foley, M. E. (1999). Developing leadership as a staff nurse. In C. A. Fetters Anderson (Ed.), *Nursing student to nursing leader* (pp.108-119). Albany, NY: Delmar Publishers.

Frone, M. R., Russell, M, & Cooper, M. L. (1991). Relationship of work and family stressors to psychological distress: The independent moderating influence of social support, mastery, active coping, and self-focused attention. *Journal of Social Behavior and Personality, 6*, 227-250.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. Chicago, IL: Aldine.

Golden, A. G. (2002). Speaking of work and family: Spousal collaboration on defining role-identities and developing shared meanings. *Southern Communication Journal, 67*, 122-141.

Gonyea, J. G., & Googins, B. K. (1992). Linking the worlds of work and family: Beyond the productivity trap. *Human Resource Management, 31*, 209-226.

Gordon, S. (2005). *Nursing against the odds: How health care cost cutting, media stereotypes, and medical hubris undermine nurses and patient care*. Ithaca, NY: IRL Press.

Greenhaus, J. H., & Beutell, N. J. (1985). Sources of conflict between work and family roles. *Academy of Management Review, 10*, 76-88.

Halldorsdottir, S. (1990). Five basic modes of being with another. In D. A. Gaut & M. M. Leininger (Eds.), *Caring: The compassionate healer* (pp.37-50). New York: National League for Nursing Press.

Hill, E. J., Hawkins, A. J., & Miller, B. C. (1996). Work and family in the virtual office. *Family Relations, 45*, 293-301.

Hochschild, A. R. (1997). *The time bind: When work becomes home and home becomes work*: New York: Henry Holt.

Holmer-Nadesan, M. (1996). "Organizational identity and space of action." *Organization Studies, 17,* 49-81.

Kirby, E. L., Golden, A. G., Medved, C. E., Jorgenson, J., & Buzzanell, P. (2003). An organizational communication challenge to the discourse of work and family research: From problematics to empowerment. *Communication Yearbook, 27,* 1-43.

Kirby, E. L., & Krone, K. J. (2002). "The policy exists but you can't really use it": Communication and the structuration of work-family policies. *Journal of Applied Communication Research, 30*, p. 50-77.

Larkey, L., & Morrill, C. (1995). Organizational commitment as symbolic process. *Western Journal of Communication, 59*, 193-213.

Larson, G. S., & Pepper, G. L. (2003) Strategies for managing multiple organizational identifications: A case of competing identities. *Management Communication Quarterly, 16*, 528-557.

Larson, G. S., & Tompkins, P. K. (2005). Ambivalence and resistance: A study of management in a concertive control system. *Communication Monographs, 72*, 1-21.

Lindlof, T. R., & Taylor, B. C. (2002). *Qualitative communication research methods* (2nd ed.). Thousand Oaks, CA: Sage.

Loscocco, K. A., & Rochelle, A. R. (1991). Influences on the quality of work and nonwork life: Two decades in review. *Journal of Vocational Behavior, 39*, 182-225.

Malone, B. L., & Marullo, G. (1997). *Workforce trends among U.S. registered nurses: A report for the International Council of Nurses ICN Workforce Forum.* Retrieved October 4, 2006, from http://nursingworld.org/readroom/usworker.htm

Mayo Clinic. (2006). *Mayo's Mission.* Retrieved November 20, 2006, from http://www.mayoclinic.org/about/missionvalues.html

Medved, C. E. (2004). The everyday accomplishment of work and family: Exploring practical actions in daily routines. *Communication Studies, 55*, 128-145.

Miller, V. D., Jablin, F. M., Casey, M. K., Lamphear-Van Horn, M., & Ethington, C. (1996). The maternity leave as a role negotiation process. *Journal of Managerial Issues, 8*, 286-309.

Nightingale, F. (1860/1969). *Notes on nursing: What it is, and what it is not*. New York: Dover Publications.

Nippert-Eng, C. E. (1996). *Home and work: Negotiating boundaries through everyday life*. Chicago: University of Chicago Press

Palmer I. (1983). Nightingale revisited. *Nursing Outlook, 31*, 229–233.

Piotrokowski, C. S. (1979). Work and the family system: A naturalistic study of working-class and lower middle-class families. New York: Free Press.

Porter S. (1992) Women in a women's job: the gendered experience of nurses. *Sociology of Health and Illness, 14*, 510-527.

Putnam, L. L., Grant, D., Michelson, G., & Cutcher, L. (2005). Discourse and resistance: Targets, practices, and consequences. *Management Communication Quarterly, 19*, 5-18.

Scott, C.R., Corman, S. R., & Cheney, G. (1998). Development of a structurational model of identification in the organization. *Communication Theory, 8*, 298-336.

Steinberg, L. D. (2004). *The ten basic principles of good parenting*. New York: Simon & Shuster.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Thousand Oaks, CA: Sage.

Tappen, R. M. (2001). Nursing leadership and management: Concepts and practice (4th ed.). Philadelphia, PA: F. A. Davis.

The Birth Center (2007). *Complete healthcare for women and their families*. Retrieved February 26, 2007, from http://www.thebirthcentermt.com

Thompson, C. A., Beauvais, L. L., & Lyness, K. S. (1999). When work-family benefits are not enough: The influence of work-family culture on benefit utilization, organizational attachment, and work-family conflict. *Journal of Vocational Behavior, 54*, 392-415.

Tompkins, P. K., & Cheney, G. (1985). Communication and unobtrusive control in contemporary organizations. In R. McPhee & P. K. Tompkins (Eds.), *Organizational communication: Traditional themes and new directions* (pp. 179-210). Newbury Park, CA: Sage.

Tracy, S. J., & Trethewey, A. (2005). Fracturing the real-self↔fake-self dichotomy: Moving toward "crystallized" organizational discourses and identities. *Communication Theory, 15*, 168-195.

Trethewey, A. & Ashcraft, K. L. (2004). Practicing disorganization: The development of applied perspectives on living with tension. *Journal of Applied Communication Research, 32*, 81-88.

Vance (1999). Mentoring—The nursing leader and mentor's perspective. In C. A. Fetters Anderson (Ed.), *Nursing student to nursing leader* (pp.200-211). Albany, NY: Delmar Publishers.

Voydanoff, P. (1989). Work and family: A review and expanded conceptualization. In E. B. Goldsmith (Ed.), *Work and family: Theory, research, and applications* (pp. 1-22). Newbury Park, CA: Sage.

Weingarten, C. T. (1999). The role of faculty in developing leadership in students. In C. A. Fetters Anderson (Ed.), *Nursing student to nursing leader* (pp.86-106). Albany, NY: Delmar Publishers.

U.S. Census Bureau (2005). *Statistical abstract of the United States*. Washington, DC: U.S. Government Printing Office.

APPENDIX A: INTERVIEW INSTRUMENT

1. Tell me about yourself
    A. What is your job title?
    B. What are you responsible/what is your role within the organization?
    C. How long have you been a nurse?

2. What does it mean to be a "good" employee at _____ (health service organization)?
    A. How did you learn what this idea meant?
    B. Can you tell me a story that describes what it means to be a "good" employee?

3. What does it mean to be a "good" nurse?
    A. How did you learn what this idea meant?
    B. Can you tell me a story that describes what it means to be a "good" nurse?

4. Does being a "good" nurse ever conflict with being a "good" employee, or does being a "good" employee ever conflict with being a "good" nurse?
    A. Explain. Why or why not?
    B. Is there a specific instance?
    C. If yes, how do you know which to follow? Which do you follow?

5. Does being a "good" nurse ever complement being a "good" employee, or does being a "good" employee ever complement being a "good" nurse?
    A. Explain. Why or why not?
    B. Is there a specific instance?

6. What does it mean to be a "good" family member?
    A. How did you learn what this idea meant?
    B. Can you tell me a story that describes what it means to be a "good" family member?

7. Do the meanings for "good" employee, "good" nurse, and "good" family member ever conflict with each other?
    A. Explain. Why or why not?
    B. Is there a specific instance?
    C. If yes, how do you know which to follow? Which do you follow?

8. Do the meanings for "good" employee, "good" nurse, and "good" family member ever complement each other?
    A. Explain. Why or why not?
    B. Is there a specific instance?

9. What does it mean, to you, to have "good" work-family balance?
    A. How did you learn what this idea meant?
    B. How does being a man/woman influence the ways in which you try to achieve work-family balance?

10. Is there anything else you'd like to add? Anything else you think is important for me to understand?

11. Any questions for me?

12. Thank them for their time. Their responses have been extremely valuable.

13. Ask for contact information of anyone else who might be interested.

APPENDIX B: INFORMED CONSENT FORM

EXPLANATION OF PROJECT & INFORMED CONSENT FORM

Please read this form and ask any questions you may have before you agree to be in this study. This study is being conducted by Claire Spanier as a part of her thesis under the direction of Dr. Gregory Larson at the department of communication studies at the University of Montana.

Procedure: You are being asked to take part in this research study because you have first-hand experience of the everyday experience of nurses and nursing.

Potential Benefits: You will receive no direct compensation, either financial or otherwise, for participating in this study. However, in the long run, this study may provide a better understanding of the specific everyday struggles and tensions nurses experience. It may also help you to understand these experiences.

Potential Risks: There are two potential risks for those who participate in this study. First, this study will require a time commitment of approximately 30 minutes to one hour. Second, in the process of these interviews, you may experience some mild discomfort in talking about your experiences. If you experience any discomfort, please contact the Missoula Mental Health Center at (406) 532-9700.

Compensation for Injury: Although we do not foresee more than minimal risk associated with this study, the following liability statement is required in all University of Montana consent forms.

"In the event that you are treated as a result of this research you should individually seek medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement or compensation pursuant to the Comprehensive State Insurance Plan established by the Department of Administration under the authority of M.C.A., Title 2 Chapter 9. In the event of a claim for such injury, further information may be obtained from the University's Claims representative or University Legal Counsel." (Reviewed by University Legal Counsel. July, 6, 1993).

Voluntary Participation and Rights: Your participation in this study is completely voluntary and will have no impact on your rights as an employee or condition of your employment. You have the right to stop the interview at any time and withdraw from the study completely. You have the right to skip over any question for any reason (or for no reason) and answer only the questions you feel comfortable answering. You have the right to strike any previous responses from the record at any time during the interview or after the interview is complete. Your participation has neither a positive nor a negative impact on your relationship with the University of Montana.

Confidentiality: This study will protect confidentiality. Each interview will be tape-recorded. However, audiotapes will only be used in order to ensure that the accuracy of the information and will be transcribed in text form. The audiotapes and transcriptions will be stored under lock and key at a safe location. Original names will be omitted from the transcriptions and your confidentiality will be protected. Only I (Claire Spanier) and my faculty supervisor (Dr. Larson) will have access to the audiotapes, transcriptions, and interview notes. After gathering the necessary information, the audiotapes will be destroyed.

All data collected as a part of this project are the property of the researcher. Participants of this study will only have access to the general findings of this study. They will not have access to audiotapes of interviews, transcriptions, and/or handwritten notes taken during the interviews.

Questions: If you have any questions about the research now or during the study, please contact Claire Spanier at **claire.spanier@umontana.edu** or by calling (406) 396-0423. You may also contact Dr. Gregory Larson at **greg.larson@mso.umt.edu** or by calling (406) 243-4161. If you have any questions regarding your rights as a research participant, you may contact the Chair of the Institutional Review Board (IRB) through the University of Montana Research Office at (406) 243-6670.

Statement of Consent: I have read the above information and have been informed of the risks and benefits involved, and all questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by a member of the research team. As such, I voluntarily consent to participate in this study.

Name: _____
     (please print clearly)

Signature: _____   Date: _____

Signature of investigator: _____   Date: _____

APPENDIX C: CODING SCHEMES

Open Codes
1. GE, GN, GFM ("good" employee, "good" nurse, "good" family member)
2. Hardworking
3. Model healthy behaviors
4. Inconsistent
5. Follow policies
6. Break rules
7. Caring
8. Critical thinking
9. Teamwork
10. Handle many projects
11. Flexible schedule
12. "I love what I do"
13. Work stress stays at work
14. No more caring left
15. Cranky sick people
16. Powerlessness
17. "Normal" schedules
18. Thankless job
19. Lack of respect
20. Taking work home
21. I support physician
22. I'm NOT a physician
23. Progression of field
24. Little white hats
25. Team rules
26. Watching others
27. My parents worked, I work
28. Helping each other out

Axial Codes / Themes
1. Definitions
2. Complimentary identities
3. Competing identities
4. Professional Hierarchy
5. Social Group Influence
6. Gender