Self-Care as a Pedagogical Ontology in the Professional Care Practice of Others and with Others: A Hermeneutic Phenomenology of Self-Care in Nursing Education

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Abstract

Healthcare practitioners work in reciprocally dynamic roles in which their health and well-being directly impact their professional competence. This interplay is often understated in ways that regulatory colleges influence training and education programs. In Ontario, for example, we see this in nursing. Although the College of Nurses of Ontario stipulates nursing professional competencies, it does not provide explicit performance expectations related to nursing self-care (i.e., the intentional way one takes care of one’s self). Accordingly, not all Ontario nursing education programs teach self-care. Different from research that deliberates nursing as a discipline or body of knowledge, this research examined how self-care is articulated, prioritized, taught, and assessed in nursing education. As such, the scholarly contribution it offers in the context of education is a pedagogy supporting self-care as a professional competency. Eight nursing faculty shared their lived experiences (through one-on-one interviews) surrounding the notion and phenomenon of self-care in nursing. Through a reiterative hermeneutic interchange that focused on whose voice is missing, an art-informed method that paralleled knowledge creation metaphorically according to the depth and breadth of “delving beneath the surface,” transformed participants spoken words into interpretive texts. Study conclusions suggest that self-care in nursing may be understood and taught through emotionally engaged self-reflection, not as a prescribed set of behaviours or individual task-based activities, but instead, as a pedagogical ontology in the professional care practice of others and with others. To foster successful self-care practice in nursing, educators should consider using arts-based methods to help learners enter and navigate spaces for emotionally engaged self-reflection. Given the urgent need for innovative and
rigorous curriculum to support successful self-care practices as part of a healthcare practitioner’s professional role, this research is both timely and relevant.
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Dedication: Prayer of Thanksgiving

God of all blessings,
source of all life, giver of all grace:
We thank you for the gift of life:
for the breath that sustains life,
for the food of this earth that nurtures life,
for the love of family and friends without which there would be no life.
We thank you for the mystery of creation:
for the beauty that the eye can see,
for the joy that the ear may hear,
for the unknown that we cannot behold filling the universe with wonder,
for the expanse of space that draws us beyond the definitions of our selves.
We thank you for setting us in communities:
for families who nurture our becoming,
for friends who love us by choice,
for companions at work,
who share our burdens and daily tasks,
for strangers who welcome us into their midst,
for people from other lands who call us to grow in understanding,
for children who lighten our moments with delight,
for the unborn, who offer us hope for the future.
We thank you for this day:
for life and one more day to love,
for opportunity and one more day to work for justice and peace,
for neighbors and one more person to love and by whom be loved,
for your grace and one more experience of your presence,
for your promise:
to be with us,
to be our God,
and to give salvation.
For these, and all blessings,
we give you thanks, eternal, loving God,
through Jesus Christ we pray.
Amen.

(V. C. Anderson, n.d.)
Table of Contents

Abstract .............................................................................................................. ii
Acknowledgments ......................................................................................... iv
Dedication: Prayer of Thanksgiving .............................................................. vi
Table of Contents .......................................................................................... viii
List of Tables ................................................................................................ xi
List of Figures ................................................................................................ xii

CHAPTER ONE: STUDY INTRODUCTION .................................................. 1
Research Context .......................................................................................... 4
Purpose Statement and Research Questions .............................................. 6
Study Significance ......................................................................................... 7
Researcher’s Lens ......................................................................................... 8
Scope and Limitations .................................................................................. 11
Study Summary ............................................................................................ 13
Organizational Outline for the Document Remainder ......................... 14

CHAPTER TWO: REVIEW OF THE LITERATURE .................................. 16
A Language Frame to Explore Self-Care in Relation to Caring for Others ......................................................................................... 17
Humanism ..................................................................................................... 17
Structuralism ................................................................................................ 19
Post-structuralism ......................................................................................... 21
Logocentrism and Différance ..................................................................... 22
Ideology and Interpellation ........................................................................ 25
Care of the Self ............................................................................................ 30
Identity Theory ............................................................................................ 37
Social and Cultural Contexts of Identity Theory ....................................... 40
Professional Identity in Nursing Education ................................................. 42
Identity Crisis ............................................................................................... 44
Identity Change Theory .............................................................................. 45
Narrative Identity ......................................................................................... 47
Metaphors and Imagery ............................................................................. 48
Hegemonic Identity ..................................................................................... 50
The Pedagogy of Care ................................................................................ 51
In a Different Voice ...................................................................................... 52
Caring: A Relational Approach to Ethics and Moral Education .......... 55

CHAPTER THREE: METHODOLOGY AND PROCEDURES ........ 58
Philosophical Orientation and Methodological Framework ................. 58
Study Design ............................................................................................... 60
Research Population/Participant Selection ............................................. 60
Data Collection ........................................................................................... 63
Data Interpretation ..................................................................................... 64
Ethical Considerations ............................................................................. 71
Restatement of the Study Purpose ................................................. 73

CHAPTER FOUR: FINDINGS AND DISCUSSION ................................. 75
Post-Structural Analysis of Nursing Professionalism and Self-Care ...... 78
Interview Context ............................................................. 85
Abbey ........................................................................... 85
Rose ............................................................................ 86
Dan ............................................................................. 87
Collette and Matt .................................................................. 88
Laura ............................................................................ 89
Shannon ........................................................................ 89
Sandi ........................................................................... 90
What is Nursing Professionalism? .................................................. 91
“Looking the Part and “Picture-Perfect” ........................................ 92
Ethical Virtues of the “Good Nurse” ........................................... 94
“Being” a Nurse Professional .................................................. 96
“Having” knowledge/competence and ethics/morals ....................... 98
Nursing professionalism as “something” ...................................... 99
Stories of “Unprofessionalism” .................................................... 101
Stories of Bullying .................................................................. 102
Abbey’s Story of Bullying ....................................................... 102
Laura and Dan’s Stories of Bullying ........................................... 103
Sandi’s Story of Bullying ....................................................... 104
Stories of Cheating ................................................................ 105
Matt’s Story of Cheating and Ethical Conflict .............................. 105
Sandi’s Story of Cheating and Ethical Conflict .............................. 106
What is Nursing Self-Care? ......................................................... 109
Metaphors and Imagery .......................................................... 109
Kicking Off My Shoes! ........................................................... 110
Meeting Basic Physical Needs .................................................. 111
Balance and Blindsight ........................................................... 117
Stories of Self-Care Crisis ........................................................ 120
Stories of Caring for Others and Making a Connection ................. 122
Emotional Engagement, Self-Reflection, and the Chronotope of Self-
Care .................................................................................. 125
Teaching and Assessment .......................................................... 131
Teaching and Assessing Professionalism in Nursing Education ...... 131
Teaching and Assessing Self-Care in Nursing Education ............... 132
Being a Nurse Professional and Not Having “Good” Self-Care .......... 135
Strategies ........................................................................... 136
Professional Circumstances that Make Self-Care Education More
Relevant .............................................................................. 136
Consequences of Seeking Emotional/Mental Self-Care Support—“It’s
like a Reprimand” .................................................................. 138
CHAPTER FIVE: CONCLUSIONS AND IMPLICATIONS .......... 141
Self-Care as a Professional Competency in Nursing Education .......... 141
What is Nursing Professionalism? ........................................ 143
What is Nursing Self-Care? .............................................. 145
Teaching and Assessing Self-Care and Professionalism in Nursing Education ......................................................... 149
Implications/Recommendations for Future Areas of Inquiry ............. 150
   Emotions, Identity, and Self-Reflection ................................ 151
   The Power and Pedagogy of Reflection .............................. 153
   Guided Arts-Informed Reflections ................................. 157
Conclusions and Final Thoughts ............................................. 158
References ........................................................................... 160
Appendix A: Semi-structured Interview Questions ......................... 184
List of Tables

Table 1: Participant Demographics .......................................................... 61
Table 2: Notation Table of Transcription Codes ........................................ 65
Table 3: Hierarchical Categories of Nursing Self-care .............................. 79
Table 4: Hierarchical Categories of Nursing Professionalism ...................... 81
# List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fig. 1</td>
<td>Conceptual Framework for Entry-Level Registered Nurse Competency Practice</td>
<td>31</td>
</tr>
<tr>
<td>Fig. 2</td>
<td>NVivo Screenshot Illustrating Interview Excerpts Coded Under “Burnout”</td>
<td>68</td>
</tr>
<tr>
<td>Fig. 3</td>
<td>NVivo Screenshot Illustrating the Organization of Sub-Themes into Over-Arching Themes</td>
<td>69</td>
</tr>
<tr>
<td>Fig. 4</td>
<td>A Five-Part Hermeneutic Circle of Understanding According to the Metaphoric Stages of Narrative Interpretation</td>
<td>72</td>
</tr>
<tr>
<td>Fig. 5</td>
<td>A Digital Collage of Word Ward II Nursing Recruitment Posters, Embodying the Notion of the Happy, Smiling, “Picture Perfect” Nurse</td>
<td>95</td>
</tr>
<tr>
<td>Fig. 6</td>
<td>Nurses’ Shoes</td>
<td>112</td>
</tr>
<tr>
<td>Fig. 7</td>
<td>Maslow’s Hierarchy of needs</td>
<td>114</td>
</tr>
<tr>
<td>Fig. 8</td>
<td>Blindsight</td>
<td>119</td>
</tr>
<tr>
<td>Fig. 9</td>
<td>Clock Eye</td>
<td>124</td>
</tr>
<tr>
<td>Fig. 10</td>
<td>Cross (2007) Reinterprets Maslow’s Hierarchy of Needs Through Indigenous Eyes</td>
<td>148</td>
</tr>
</tbody>
</table>
CHAPTER ONE: STUDY INTRODUCTION

Writing is nothing but the representation of speech; it is bizarre that one gives more care to the determining of the image than to the object (Rousseau, J.J, as cited in Derrida, 1967/1997, p. 27).

Different from research that deliberates nursing as a discipline or body of knowledge, this research examined how self-care is articulated, prioritized, taught, and assessed in nursing education. As such, the scholarly contribution it offers in the context of education is a pedagogy supporting self-care as a professional competency. Eight nursing faculty shared their lived experiences (through one-on-one interviews) surrounding the notion and phenomenon of self-care in nursing. Through a reiterative hermeneutic interchange that focused on whose voice is missing, an art-informed method that paralleled knowledge creation metaphorically according to the depth and breadth of “delving beneath the surface,” transformed participants spoken words into interpretive texts.

A post-structural analysis of interview transcripts revealed that self-care is hierarchically organized around age, maturity, and professional exposure to risk and stress, whereas professionalism is hierarchically organized around experience, professional role, gender, emotional stability, education, and employment status. When asked what nursing self-care and professionalism was, participants responded with stories of what nursing self-care and professionalism was not. Stories centered on self-care crisis, caring for others, emotionally engaged self-reflection, and nursing colleagues and students who acted unprofessionally by bullying and cheating. Key metaphors used to
uncover the deeper meaning behind participants’ stories supported the self-care themes of “balance” and “blindsight,” and professionalism as “looking the part.” Themes overlapping both self-care and professionalism centered on contradictions within the nursing role as being an “ethical paradox” and “negotiated identity.”

Although all participated reported that being a nurse professional was something they “loved,” some participants described it as an inherent yet elusive state of “being”—something for which not everyone is capable. Half the participants felt that self-care education is needed more in situations where there is a lot of death and tragedy, whereas the others felt self-care is important in all areas of nursing.

Nurses who were depicted as taking “good” care of themselves (i.e., “exercising and eating healthy”) were no more advantaged (compared to nurses who did not take “good” care of themselves), to describe “entering” deep moments of emotionally engaged self-reflection. In these moments, participants framed their experiences of “livingness” in directional and metaphorical relation to encounters of “stepping away” and “taking time” from something that did not physically exist; they narrated transformative encounters of altered consciousness where they emotionally connected to someone or something greater than their solitary selves. Through this spirit of connection, participants gained a renewed sense of energy, acceptance, purpose, and meaning within their professional roles.

Although all participants cited the value of reflection for self-care and as a protective strategy against stress, burnout, and mental health issues, when it came to seeking care for these issues, participants reported that many students and practicing nurses struggle to disclose their need for care due to the fear of reprimand and being
perceived as “unprofessional.” Similarly, although all participants agreed that it is not possible to sustain being a nurse professional without engaging in “good” self-care practices, because self-care is something “learned but not taught,” they reported significant challenges with the way it is assessed (i.e., as individual, task-based, written assignments linked to students’ marks). Some participants remarked that students don’t “buy-in” to the reflective journaling process, thinking they’ve “reflected to death” or “what they do actually write is superficial—not very deep.”

Conclusions of this study suggest that self-care in nursing may be understood and taught through emotionally engaged self-reflection, not as a prescribed set of behaviours or individual task-based activities, but instead, as a pedagogical ontology in the professional care practice of others and with others. To foster successful self-care practice in nursing, educators should consider using arts-based methods to help learners enter and navigate spaces for emotionally engaged self-reflection. Given the urgent need for innovative and rigorous curriculum to support successful self-care practices as part of a healthcare practitioner’s professional role, this research is both timely and relevant.

In this first chapter, the discourse surrounding the research topic is introduced. I describe the purpose of this study, the research questions I have sought to explore, the study’s significance, scope, and limitations. Before concluding this chapter with a summary and organizational layout for the remainder of this document, I present my research lens and the reason why I have been called to investigate the research described in this paper.
Research Context

For someone to develop genuine compassion towards others, first he or she must have a basis upon which to cultivate compassion, and that basis is the ability to connect to one’s own feelings and to care for one’s own welfare. . . Caring for others requires caring for oneself. (Dalai Lama, as cited in Mills & Chapman, 2016, p. 87)

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Nursing is a profession built on the principal of compassionate care. Often the terms “nursing care” and “compassionate care,” where care is enacted by one person (i.e., “the nurse”) toward another (i.e., “the patient”) are synonymous (Mills, Wand & Fraser, 2015). Nevertheless, the extent to which nurses balance care, by allowing themselves to engage in compassionate self-care (i.e., as an intentional way one takes care of one’s self) is often overlooked or undervalued within nursing practice (Blum, 2014). In fact, many nurses struggle, both with the concept of self-care as an ethical stance that “could be seen to foster a culture of selfishness,” (Mills, Wand, & Fraser, 2015, p. 791) and meaningful ways to enact it (Blume, 2014; Sheppard, 2016). While much of the current literature surrounding nursing care and compassionate has focused on the detrimental aspects of “over-caring,” (i.e., compassion fatigue/burnout), when nurses overlook their need for self-care, their “therapeutic use of self in the provision of compassionate care to patients” is compromised (Mills, Wand, & Fraser, 2015, p. 791). As such, nurses work in a reciprocally dynamic role in which their health and well-being directly impact their professional competence. This interplay of personal self-care practice (i.e., the intentional way one takes care of one’s self) and professional competence (i.e., a person’s
attitude and aptitude to perform one’s job) is often understated within the legislative frame of how regulatory colleges influence healthcare education training programs. In Ontario, for example, we see this in nursing. Although the professional practice standards for Ontario nurses (i.e., the College of Nurses of Ontario, “CNO”) stipulates that nurses must maintain professional practice standards throughout their careers (CNO, 2002/2018), it does not provide explicit performance expectations related to nursing self-care. As a result, not all nursing education programs in Ontario teach self-care as part of their curriculum (Docherty-Skippen, Hansen, & Engle, 2019). From a health equity perspective, this is problematic, since self-care has been linked in nursing and across the healthcare professions, as a protective strategy against workplace stress and burnout (Ang et al., 2018; Crowe, 2015; Fida, Laschinger, Spence, & Leiter, 2018; Kwong, 2016; Low, King, & Foster-Boucher, 2019).

According to the Mayo Clinic (2018), burnout is a “special type of work-related stress—a state of physical or emotional exhaustion that also involves a sense of reduced accomplishment and loss of personal identity.” Compared to all other employment sectors in Canada, nurses are twice as likely to be absent from their job due to illness or injury attributed to job burnout, and nearly half of working nurses suffer from depression and symptoms of job-induced post-traumatic stress disorder (CIHI, 2017; CFNU, 2017; RNA, 2017). For nursing students and entry-level nurses, this issue is even more pronounced (Babenko-Mould and Laschinger, 2014; Boamah et al., 2017; Gibbons, 2010; Hensel and Laux, 2014; Laschinger et al., 2015; Laurencelle and Scanlan, 2018; Price et al., 2018; Reyes et al., 2015).
Despite growing evidence and concern that burnout negatively affects the sustainability of Canadian nursing practice (i.e., practitioners with or at risk of burnout are more likely to make medical errors, deliver substandard patient care, experience greater health issues, and face higher job attrition compared to practitioners without burnout) (Berrios et al., 2015; Epp, 2012; Harwood et al., 2010; Wu, Singh-Carlson, Odell, Reynolds, & Su, 2016), very little is known about the way that self-care, as a protective strategy against burnout, is taught and assessed as a professional competency in nursing education (Docherty-Skippen, Hansen, & Engel, 2019). Although many nursing education programs are working toward implementing self-care curricula because no standard definition exists to describe what nursing self-care is, it is unclear how self-care relates to a nurse’s professional competency. Furthermore, as resilience is thought to be a protective strategy against stress and burnout in nursing students (Liang et al., 2019; Thomas and Asselin, 2018), it is uncertain how the emotional and relational elements of self-care impacts resilience and nursing professionalism. Accordingly, there is a paucity in the development and assessment of nursing self-care curricula that effectively prepare its students for successful and sustainable employment. To help nursing education programs adequately prepare its students for successful and sustainable employment, it is important first to understand, from a faculty perspective, what nursing self-care is and how it relates to professional competency.

**Purpose Statement and Research Questions**

The purpose of this study was to explore the notion and phenomenon of self-care (i.e., the intentional way one takes care of one’s self), as a professional competency in
nursing education. From a nursing faculty perspective, this study sought to address the following research questions:

1) How is self-care articulated as a professional competency in nursing?
   a. How be this illuminated through a post-structural lens?

2) How is self-care prioritized, taught, and assessed in nursing education?
   a. Are there professional circumstances that make the need for self-care education more relevant?
   b. Is it possible to be a nurse professional without engaging in positive self-care strategies? Why or why not?

**Study Significance**

Differing from other nursing education research that deliberates nursing as a discipline and body of knowledge, this research examined the notion and phenomenon of self-care (i.e., how it is articulated, prioritized, taught, and assessed) in nursing. As such, the substantive scholarly contribution this research offers in the context of education is a pedagogy that supports self-care as a professional competency. The need for this research is timely and relevant, as there is an urgent demand for innovative and rigorous curricular design to support nurses’ self-care practices as part of their professional role (Docherty-Skippen, Hansen, & Engle, 2019). According to a paper commissioned by the Canadian Federation of Nurses Union (2015), “burnout, fatigue, absenteeism, injury, incivility, and decreased quality of patient care leads to the detrimental effects of a potential nursing shortage” (p. 18).

In other professional and vocational training programs that report high levels of burnout due to insufficient self-care practices or ethical disparity (caused by a mismatch
in values), findings from this study may be relevant. Professions such as medicine, teaching, and law, all report such issues (Mucalov, 2019; Sanchez-Reilly et al., 2013; Stock, Sameshima, & Slingerland, 2016; Stockwell, 2018). Likewise, in professional circumstances where issues of capacity for self-assessment, ability to care for others, and the capacity to act on others’ behalf are linked to the professional role, this research may have added significance.

**Researcher’s Lens**

I articulate my lens as a caregiver, researcher, and educator who works in a caregiving profession. Through this lens, I am called to this research because I care. Sometimes, however, the care needs of those for whom I care (at work, at home, and in my community), have overshadowed my personal self-care needs.

Several years ago, I worked as a research coordinator/patient educator at a large research-intensive teaching hospital. In that role, I provided patient education and coordinated clinical research studies with children and adults who had auto-immune diseases and metabolic disorders. At the time, I had two young children, a husband, aging parents for whom I cared, and I volunteered with several non-profit, community-based organizations for persons living with disabilities.

At work, my job was demanding. I felt pressured to work long and irregular hours. I worked in constricted spaces and frequently encountered biological, chemical, and radioactive hazards. I managed two research laboratories, over a dozen research studies, and at any given time, I supervised up to a dozen undergraduate and graduate students in data collection and analysis. In addition to these responsibilities, I taught in the university’s clinical research training program, I collected and analyzed all types of
data (e.g., biological specimens, questionnaires, medical charts, observational, experimental, and statistical data sets), I organized and hosted accredited continuing medical education conferences, patient support groups meetings, patient education events, research training, and fund-raising activities. I developed funding partnerships with over a half-dozen pharmaceutical companies, and I developed education, advocacy, and volunteer relationships with over a dozen patient support organizations and research centres across Canada. Almost half of my work involved direct patient contact. Some of the patients I worked with were critically ill. Some of the patients I worked with died.

Over time, as the intensity of my work demands increased, my health changed. I became physically, emotionally, and mentally exhausted. Then, when an aggressive co-worker started harassing me, I became unraveled. I didn’t have the resilience to recognize or remedy what was happening. Unable to navigate the situation, I became worn thin, burnout, and clinically depressed. First, I went on short-term disability leave. Then, after a very public and unsuccessful return to work process (my supervisors and colleagues had been made aware of the medical reasons for my leave, the workplace harassment escalated, and many of my job responsibilities were “re-structured”), I was forced to leave my job altogether. Confused and uncertain about my illness experiences and how those experiences influenced my personal and professional identity, in search of answers, I went back to university to study education at the master’s level.

Now, in the final stage of completing a doctoral degree in education, I have a better understanding of myself, of my own self-care needs, and my changing identity as a caregiving person and caring professional. I also recognize that my experiences and struggles with illness and disability, family responsibilities, high work demands, and job
burnout are not unique. Many high-functioning professionals with stressful workloads and home caregiving responsibilities, like me, have experienced the onset or relapse of serious mental and physical health conditions triggered by occupational burnout (Jones, D., 2003; Jones, J., 2015; “Workplace Mental Health Promotion,” 2015). According to the Workplace Mental Health Promotion website,

working in professions with high job demands and few supports can increase the prevalence of burnout . . . Helping professions, such as jobs in healthcare, teaching or counseling, report high rates of burnout. Burnout can stem from many negative conditions at work . . . [and it] can be hazardous to an employee’s health. It is positively related to many mental and physical health problems, including depression, anxiety, and psychosomatic health complaints.

To tackle this issue from a remedy lens, (opposed to a deficit perspective that focuses on the detrimental effects of burnout), as a way forward, I am called to this research from an ethical stance of care. Informing my research are my lived experiences. I have worked in a health education setting, experienced and “recovered” from physical and mental illness triggered by occupational burnout, and I have studied the complex dynamics of identity and professional identity formation. I am compassionate to and cognizant of the types of ethical issues and tensions that arise in a healthcare/health education setting. Most important however, from my own lived experiences, trying to make sense of what it means to “survive,” as a professional, the stigma associated of having mental illness, I have an embodied understanding of what it means to “be open and invite reciprocal sharing with a feeling of safety—not judgment . . . by privileging listening over talking,
by caring, and by building on what each other shares during the dialogic process”


**Scope and Limitations**

This research study used a qualitative hermeneutic phenomenological design to explore the notion and phenomenon of self-care (i.e., the intentional way one takes care of one’s self) as a professional competency in nursing. The scope and limitations of this study, therefore, applies not only to research topic (i.e., the way that self-care is articulated, prioritized, taught, and assessed in nursing education), but the way the research topic has been as experienced and articulated by study participants and the way it has been interpreted through my research lens.

When interpreting phenomenological experiences as narrative *fact*, an assumption is made that people make sense of their experiences through the necessity of stories. We elect to *tell* certain details of our experiences, based on the significance we apply to those details, and we chose to sequence those details in ways that mirror or fit within the repertoire of our storied experiences (Bell, 2019). Following this same logic, we elect to *interpret* certain details of others’ experiences, based on the significance we apply to those details and the way those details have been sequenced to resonate within the repertoire of our storied experiences. As such, to appreciate research findings as narrative *facts*, it is imperative to acknowledge that the concept of *fact* or *truth*, is relative to both the telling and interpretation of storied experiences. This narrative relativity, which will further be discussed in chapter four, is encapsulated within the indeterminant boundaries of a time-space continuum referred to by Bakhtin (1981), as a literary *chronotope*. Consequently, as this research study’s narrative text unfolds today,
tomorrow, and each day after that, it does so with nuanced adaptations that differ from what unfolded yesterday, the day before that and each day, therefore. Hence, the limitations of this study are bound by the chronotopic configurations of language and discourse, in its “livingness,” that is “the quality, condition, or fact of being alive or living; vital force; vigour, vivacity, vividness” (The English Oxford Living Dictionaries, n.d.), shared between participants and researcher.

From research participants to researcher to readers, generalizability considerations are continually evaluated during the data collection and interpretation processes. To do this, I have endeavoured to narrate the text in a naturalistic manner by including “thick descriptions” of the phenomenon itself backed with “robust” and comprehensive accounts of the data collection process (Lincoln & Guba, 1985). Finer points about the interview process, (i.e., where, when, and, how the interviews took place), have been made apparent so that a “richer” and “fuller” understanding of the study background may be illuminated (Lincoln & Guba). By drawing links between the study participants’ storied voices framed within this research query, readers may compare their storied lives and the storied lives of familiar others.

Confounding variables that may disrupt the study’s generalizability and transferability are inherent to the social, cultural, and political characteristics of the communities in which study participants work. In recognition of this limitation, demographic details related to participants’ practice location (i.e., urban, rural, remote), area of sub-specialty/interest, the number of years working as a nurse and teaching within a nursing faculty have been documented.
Study Summary

Healthcare practitioners work in reciprocally dynamic roles in which their health and well-being directly impact their professional competence. This interplay is often understated in ways that regulatory colleges influence training and education programs. In Ontario, for example, we see this in nursing. Although the College of Nurses of Ontario stipulates nursing professional competencies, it does not provide explicit performance expectations related to nursing self-care (i.e., the intentional way one takes care of one’s self). Accordingly, not all Ontario nursing education programs teach self-care. Different from research that deliberates nursing as a discipline or body of knowledge, this research examined how self-care is articulated, prioritized, taught, and assessed in nursing education. As such, the scholarly contribution it offers in the context of education is a pedagogy supporting self-care as a professional competency. Eight nursing faculty shared their lived experiences (through one-on-one interviews) surrounding the notion and phenomenon of self-care in nursing. Through a reiterative hermeneutic interchange that focused on whose voice is missing, an art-informed method that paralleled knowledge creation metaphorically according to the depth and breadth of “delving beneath the surface,” transformed participants spoken words into interpretive texts. Study conclusions suggest that self-care in nursing may be understood and taught through emotionally engaged self-reflection, not as a prescribed set of behaviours or individual task-based activities, but instead, as a pedagogical ontology in the professional care practice of others and with others. To foster successful self-care practice in nursing, educators should consider using arts-based methods to help learners enter and navigate spaces for emotionally engaged self-reflection. Given the urgent need for innovative and
rigorous curriculum to support successful self-care practices as part of a healthcare practitioner’s professional role, this research is both timely and relevant.

Organizational Outline for the Document Remainder

Chapter two presents a thematic overview surrounding the notion of caring for one’s self (or self-care) as a professional competency and pedagogical ontology towards caring for others. It begins with the development of a language frame that allows the exploration of self-care in relation to caring for others (i.e., the philosophy and language of care and self-care), identity theory (i.e., social identity theory, professional identity development in nursing, identity crisis, and narrative identity), and the pedagogy of care.

Chapter three presents the research methodology and study design considerations used in this research. Included in this chapter are sections on the philosophical orientation and methodological framework guiding this study, the research design and data interpretation processes used in this study, and the ethical considerations involved in the conduct of this research.

Chapter four presents both study results (i.e., a post-structural analysis of language constructs found in participants’ narratives) and findings. In considering beyond what is “open,” a term used by Lindseth and Norberg (2004) to describe a hermeneutic approach for interpreting human values as lived experiences, findings have been detailed as layered accounts—merging quotes, narrative, and imagery with remnants and off-shoots of critical and reflective thought.

Chapter five presents the conclusions of this research and implications for the future areas of inquiry. In this chapter, I describe how this research has contributed to the advancement of knowledge, by discussing 1) the role that emotion plays in identity, care,
and self-care work, and 2) making recommendations to teach and assess students how to enter and navigate spaces for emotionally engaged self-reflection in the professional care practice of others and with others.
CHAPTER TWO: REVIEW OF THE LITERATURE

*Illness is the night side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.*

(Susan Sontag, 1978, p. 3)

Beginning with a brief introduction about literary theory and its connection to language and philosophy, this chapter presents a thematic overview surrounding the notion of caring for one’s self (or self-care) as a professional competency and pedagogical ontology in caring for others. In the development of a language frame that allows the exploration of self-care in relation to caring for others, I draw upon the works of French philosophers and post-structuralists Jacque Derrida’s (1967/1997) “Of Grammatology”, Louis Althusser’s (1971/2014) “Ideology and Ideological State Apparatuses”, and Michel Foucault’s (1984/1986) “The Care of the Self.” I connect the theoretical concepts examined in these works, (i.e., *logocentrism* and *différance*, *ideology* and *interpellation*, and *care of the self*) to the ways that care and self-care have been valued and textualized in the College of Nurses of Ontario’s professional practice standards (2002/2018) and competencies for entry-level registered nursing practice (2014) documents and the writings of Florence Nightingale (founder of modern-day nursing). Following this, I present pedagogical theories of identity and professional identity formation in connection to nursing education. I discuss how changes in one’s identity may be narratively examined in the context of self-care and its converse corollary
(i.e., a lack of care or neglect). Next, I introduce Carol Gilligan’s (1982/1993) and Ned Noddings’ (1984/2013) pedagogy care, as a moral theory for self-care and as a pedagogical ontology in caring for others in connection to nursing education.

**A Language Frame to Explore the Self-Care in Relation to Caring for Others**

Similar to the way that Sontag (1978) described illness as “the night side of life” (p. 3), language, knowledge, and experience can simultaneously inhabit more than one way of being in this world. The moment language is textualized or captured in physical form (i.e., the language of art, music, or dance), it becomes historically, socially, and culturally situated. As the world changes (i.e., via environmental, technological, social, economic, political, and cultural conditions and events), the means and language in which we recognize and articulate ourselves also changes. New ideas, new discoveries, and new inventions emanate new philosophies, new languages, and new ways of understanding (Birner, 2012). Different world-views and literary genres create different identity conditions that affect the way we speak language, (or its inverse, “the way language speaks us”), to frame or structure knowledge (Klages, 2006/2011). Understanding the philosophy behind these literary genres and how they have changed over time, provides insight into the complex process of identity formation and how we have learned to understand and embody the notions of care, caring for one’s self, and caring for others.

**Humanism**

From the time of Plato (427-347 BC) until the introduction of structuralism in the early 1960s, humanist philosophy has dominated Western-European literary
culture and societal attitudes toward the notions of truth and self-identity (Klages, 2006/2011; Lamont, 1949/1997). As a philosophy, humanism assumes the ethical position that human ideologies and interests form the essence of life and understanding (Lamont, 1949/1997). Humanist thought is based on the idea that,

Each human being has a ‘self,’ which is both unique to each individual and contains elements which are common or universal, part of ‘the human condition.’ This self is the core of our sense of identity, of who we are, as individuals and as part of any larger groups or cultures. The self is the centre of all meaning and truth and knowledge, and language is the self’s medium for unique expression of its perceptions, thoughts, and feelings. (Klages, p. 50)

To appreciate how the self posits truth, Plato formalized a distinct philosophical and methodological tradition of dialectic self-reflection and reasoning. This process, mirrored similarly to the way Socrates debated and dialogued with his students is coined “Socratic questioning” (Sedley, as cited in Benson, 2006). Outlined in his essay “The Republic,” Plato made explicit, the divergence between “opinion,” (i.e., something that “tends to run away,”) and that of “knowledge” (i.e., something that “must include the account of a cause or explanation”) (Kahn, as cited in Benson, p. 127). This distinction paved the way to Plato’s conviction that “true” knowledge, something humans are only cable of experiencing through their senses as imperfect replications, only exists in the “ideal realm” (Klages, 2006/2011; Kraut, 2004/2007). According to Plato, objects, ideas, and human essences (i.e., fundamental human forms shared by all people) that exist in the ideal realm are everlasting and unchanging entities of truth (Kahn). To
access or discover these “truths,” Plato advocated logic and reasoning as an important moral and societal responsibility (Kahn; Klages; Kraut).

From an identity perspective, Plato’s theory of knowledge has far-reaching implications. Firstly, his idea that truth and identity are entities that remain constant and unchanging leads to a single worldview that does not invite the possibility of knowledge creation. Secondly, his theory does not consider the nonlinearity of complex systems and problems that are dynamic, unpredictable, and multifaceted. Thirdly, “Plato’s main philosophical method . . . [and] worldview . . . places an altogether pivotal importance on the gift of spoken language: as the basis of dialectic, it is a privileged means to philosophy” (Sedley, as cited in Benson, 2006, p. 214). Typical in Plato’s essays are the dialectic interplays between two persons: 1) the teacher/philosopher, whose main role is to engage the student in a deliberate series of rhetorical questions, and 2) the student, whose main role is to develop a greater sense of self through the dialectic process of self-reflection and reasoning (Kahn as cited in Benson). Language, therefore, is not just “a convenient code in which to encapsulate and convey our thoughts to each other, it is the very stuff of those thoughts” (Sedley, p. 214). From this perspective, identity constructs are directly linked to the rigor and form of linguistic and language cognition available to each person. Voices and identities that centre around the more powerful domains of society, therefore, become the official voices (or official narratives) by which lesser voices and against which lesser identities are measured.

**Structuralism**

Different from a humanist way of thinking, structuralist theorists look at the idea that patterns, systems, and structures of language define reality (Rivkin & Ryan,
Structuralists do not see truth and knowledge as something derived from individuals (i.e., people do not speak language); instead, truth and knowledge are articulated and governed by the structure of language in and of itself (Klages, 2006/2011). Truth and knowledge are created through the structures (such as language) that make experience possible (Kraut, 2004/2017). In other words, *language speaks us* and the notions of *self* and *others* only exist because we have language to structure them.

In 1916, linguistic theorist Ferdinand de Saussure formally introduced the theory of structuralism (Rivkin & Ryan, 1998/2004). He posited that “language should be studied as if it were frozen in time and cut transversely like a leaf” (p. 54). Saussure proposed a system whereby language units are comprised of two parts (i.e., the concept and its sound image), which he referred to as a “linguistic sign” (Saussure, as cited in Rivkin & Ryan). Within each linguistic sign exists a “signified” and a “signifier;” the signified is an object described by a signifier, and the signifier is the language sound (or phoneme) used to signify the signified (Saussure). For example, *an apple*, the signified, is described by its signifier, *apəl*, the phoneme of the word *apple*.

Saussure’s language structure theory was premised on two central ideas. The first is that the relationship between the signified and signifier is arbitrary in that there is no semantic or syntactical relationship. For example, the notion and utterance of a word only becomes significant when it is linked “corresponding to the thing that it names” (Saussure, as cited in Rivkin & Ryan, p. 60). The relation between the signifier and signified is based on the idea of *difference* and *value*. In this respect, “value is made up solely of relations and differences with respect to the other terms of language” (p. 68).
The second point Saussure made is the idea that language functions in a linear order. Using the sentence as an example, the linearity and order of words in a sentence are easily recognized. In a sentence, “elements are presented in succession; they form a chain . . . [and are] represented in writing and the spatial line of graphic marks is substituted for succession in time” (p. 63). A structural analysis of literature, therefore, takes shape with a structural inspection of language itself. The order of words, according to specific grammatical rules, creates a universal or constant structure for which language and thought may be understood.

Understanding Saussure’s theory of linguistics allows us to separate language from speaking. This leads us to look at the way we construct “(1) what is social from what is individual; and (2) what is essential from what is accessory and more or less accidental” (Saussure as cited in Rivkin & Ryan, 1998/2004, p. 59). In this respect, identity, like language, may be viewed as “a product that is passively assimilated by the individual” (Saussure, p. 59) and as a social construct ingrained in the ways we have learned to classify and organize information to make sense of our experiences.

**Post-Structuralism**

Post-structuralism developed in response to the philosophy of phenomenology, which posits that knowledge is situated within experience (Derrida, 1967/1997). Where structuralism looks at the structure and order of language to understand and frame human experience, post-structuralism looks at language structure in relation to the systems of knowledge (or power paradigms) from which language emanates (Klages, 2006/2011). As a literary theory, poststructuralism does not consider language to be fixed or stable, just as “things that we have thought of as constant, including the notion of our own
identity (e.g., gender identity, national identity, [professional identity], for example), are not stable and fixed, but rather are fluid, changing, and unstable” (Klages, p. 50). The meaning of language, therefore, becomes situated within the social, cultural, and political context in which it is used.

**Logocentrism and différance.**

When one thinks of the word *care*, it is also easy to conjure the meaning of its converse (i.e., carelessness, neglect, or disregard). Likewise, when one thinks of the word *self*, the notion of *other* becomes significant. Saussure posited that these inverse word-relationships are essential in the structural analysis of language systems, as they allow signs (i.e., word meanings) to be determined based on their difference to other signs (i.e., in what they are not). This idea of difference, however, was the very point of deliberation which propelled Jacque Derrida’s (1967/1997) manuscript “*Of Grammatology*” and began the revolutionary movement of post-structural literary criticism.

In “*Of Grammatology,*” Derrida (1967/1997) sketched a process to examine the source and significance of language not just from a complex writing system, but also, from a deep philosophical analysis of phenomenology and “the human desire to posit a ‘central’ presence at beginning and end” (p. lxviii). He did this by extending Saussure’s analysis of language structures through the notions of “logocentrism” and “différance.”

Derrida defined *logocentrism* as “the metaphysics of phonetic writing . . . in the process of imposing itself upon the world, controlling in one and the same order” (p. 3), and *différance* as “designating the production of differing/deferring” (p. 23). In simpler terms, *logocentrism* posits that speech, not writing, is central to language (which subverts
the very presence of text) and *différance* (spelled differently than difference but sounds the same) accentuates the subversion that speech is privileged over writing.

What Derrida (1967/1997) noted in Saussure’s work, was that the system of phonetic-alphabetic writing imposed a system of binary opposites (i.e., presence of speech over the absence of speech) based on the preference of one term (i.e., the signified) over the other (i.e., the signifier). For Derrida, understanding the power relationship between language binaries, through the process of deconstruction, was essential to understanding human thought. His work drew attention to the fact that: 1) we have come to understand our world through language binaries (e.g. good/evil, male/female, presence/absence, speech/text, self/other), and 2) by deconstructing language binaries, our world can be understood through power relations.

Applying Derrida’s (1967/1997) ideas about *logocentrism* and *différance* to concepts of *caring for one’s self* and *caring for others*, the order relationships between these terms and the way that these terms are valued and textualized may be examined. We can ask ourselves questions . . . in what axiological, ontological, and textual contexts does *self* privilege *other* (or vice-versa)? Alternatively, in what axiological, ontological, and textual contexts are *self* and *other* privileged in reciprocity? Take, for instance, an examination of the family unit. We know that within the family, there exist persons who assume the relational roles of *selves* and *others* (e.g., parents, children, siblings, and so forth). In fact, in Heidegger’s (1927/1962) “Being and Time” (which Derrida used to springboard his post-structural analysis in “Of Grammatology”), Heidegger premised that our existence in the world is relational, or “being with.” However, as a unit, the
family cannot privilege the *self* over *other*, or vice-versa, because ontologically, the *self* and *others* are one and the same, “being with” or relational members of the family.

In value statements and textual structures that separate *self* from *others* or position *care for one’s self* over *caring for others*, a relationship tension of *différance* exists where one term representing one entity takes preference or privilege over the other (e.g. self over other; other over self; caring for one’s self over caring for others; care for others over caring for one’s self). We see this in the College of Nurses of Ontario’s ([CNO], 2002/2018; 2014) “Professional Practice Standards” and “Competencies for Entry-Level Registered Nurse Practice” documents. The relationship standard used to describe the professional expectations of the nursing role is described as a therapeutic “*nurse-client*” relationship, not a “*client-nurse*” relationship. This notation is curiously contradictory considering that the “Professional Practice Standards” stipulates that “clients are the central focus of the professional services that nurses provided” (CNO, 2002/2018, p. 3).

Similarly, throughout the CNO’s “Competencies for Entry-Level Registered Nurse Practice” document, the term “care for” appears four times in relation to the role expectations that nurses provide care for clients, whereas “care of” only appears once in relation to the care of the self, referenced only by a nurse’s legal obligation of self-regulation as “evaluating the standard of care of registered nurses” (CNO, 2014, p. 3). Although these points may seem trite, these textual differences have powerful implications in the way that *care* and *self-care* may be valued in nursing. By recognizing and deconstructing language binaries used to govern care and self-care in nursing, the
power dynamics and social structures of ideology and interpellation (Althusser, 1971/2014) that influence the way care is valued may be considered textually.

**Ideology and interpellation.**

In “Ideology and Ideological State Apparatuses,” Louis Althusser (1971/2014) postured two main principles: 1) “ideology represents individuals’ imaginary relation to their real conditions of existence” (p. 181), and 2) “ideology has a material existence” (p. 184). Althusser posited that all societies are composed of two controlling state apparatuses: 1) the Repressive State Apparatuses (RSAs) and 2) the Ideological State Apparatuses (ISAs). While the RSAs (such as law enforcement and the military) are organized by the government and can enforce individuals’ behaviours, the ISAs (i.e., institutions and social organizations such as schools, churches, political parties, communities, families, etc.) “generate ideologies which we, as individuals (and groups) then internalize, and act in accordance with” (Klages, 2006/2011, p. 131). In fact, Althusser rationalized that the ISAs have a greater influence on the control and regulation of people’s behaviors compared to the RSAs, because the ISAs are grounded in people’s ideologies. He described the way society adheres to ideology (whether it be religious, moral, legal or political) as “world outlooks.” These world outlooks, are largely imaginary and do not ‘correspond to reality’ . . . [but instead]
constitute an illusion . . . [and] make allusion to reality and that we need only ‘interpret’ them to discover the reality of this world beneath the surface of their imaginary representation of it (ideology = illusion/ allusion). (Althusser, p. 181) In this respect, the way that we interpret ideologies (i.e., representations of our reality) dictates our actual or true existence, and so our identities become shaped by the forces
and salutations (i.e., interpellations) of the social, ideological structures in which we operate.

Althusser (1971/2014) illustrated how ideology and interpellation dictate our reality using two key examples: 1) religious ideology from the eighteenth century, and 2) the “alienation reigning in people’s very conditions of existence” (p. 182). In the first example, Althusser stated that priests or despots are to blame.

They ‘forged’ Beautiful Lies so that people would, in the belief that they were obeying God, in fact, obey the priests or despots, generally allied in their imposture, with the priests working in the despots’ service or, depending on the aforementioned theorists’ political positions, the other way around. There is, therefore, a cause for the imaginary transposition of real conditions of existence: that cause is a small handful of cynics who base their domination and exploitation of the ‘people’ on a skewed representation of the world, which they have imagined in order to enslave minds by dominating imaginations. (p. 182)

In the second example, Althusser stated that,

people devise an alienated (that is, imaginary) representation of their conditions of existence because those conditions of existence are themselves alienating . . . because those conditions are dominated [by] the essence of alienated society: ‘alienated labour.’ (p. 182)

In simpler terms, because of the difficult conditions in which people lived and laboured, they turned to ideologies of a represented reality in which they could, vicariously, find relief/peace/contentment. State apparatuses function to “‘recruit’ subjects among individuals (it recruits them all) or ‘transforms’ individuals into subjects (it transforms
them all) through the very precise operation that we call interpellation or hailing” (p. 190). Common between both examples and essential to Althusser’s main thesis is that ‘people’ do not ‘represent’ their real conditions of existence in ideology (religious ideology or some other kind), but, above all, their relation to those real conditions of existence. That relation is at the centre of every ideological, hence imaginary, representation of the real world. It is that relation which contains the ‘cause’ that must account for the imaginary distortion of the ideological representation of the real world. (p. 183)

Extending Althusser’s ideas by considering the difficult reality imposed on society through war and disease, we can find evidence in the writings of Florence Nightingale (1820-1910), the founder of modern nursing education and practice, where religious (i.e. God), and state (i.e., the King and Country) ideology shaped the conditions of reality and interpellated the responsibility of nurses in duty obligation terms.

In the “Collected Works of Florence Nightingale,” Nightingale (cited in McDonald, 2001) used the term “duty” over a dozen times to describe her obligations/responsibilities toward the nursing profession and care of the sick and wounded. In an October 1869 letter to Sir Harry Verney, Nightingale compared the act of nursing to that of soldiering and described nursing as a duty, service, and heroism. Specifically, Nightingale wrote,

And I should be wanting in duty to mine (my profession: nurse to Her Majesty’s Service) if I did not say that I think heroism as heroic in bearing wounds and amputations as in going into battle . . . For, after all, it is not the object to go into heaven with two feet but to go there “enduring hardness,” tried in patience,
courage and goodness to the heroic degree, that is, having taken one’s degree in virtue. (p. 624)

Although Nightingale interpellated duty as an official responsibility of the nursing role as in “night duty” and “duty nurse,” she also questioned the ideology of “duty” imposed by the belief in God and the practice of religious doctrine. In “Suggestions for Thought” (cited in Calabria & Macrae, 1994) Nightingale wrote,

Duty is so difficult now; formerly it was quite certain what there was to be done. People were to go to church and teach their children the catechism and the creed, and give away flannel petticoats and broth, which was called “doing good;” there was no doubt about it . . . Some few feel, from the sensation of comfort and satisfaction in themselves, that He has answered them; other few are miserable because no such feeling in themselves gives them conviction that He has heard them. The greater part go their way, having “done their duty” in “saying their prayers,” and never look for any result at all. (pp. 8-9)

Nightingale also wrote,

Yet, while anxious to avoid the evils which experience has shown to arise in religious orders, we yet believe that associations with the object of discovering truth concerning the nature and will of God, the duty and nature of man—how to regulate life in accordance with such truth—are the probable, the natural means for causing mankind to advance in true belief, in true life. (p. 142)

Although no longer imposed by God, the terms duty and service continue to be synonymous with (and therefore serve to interpellate) the professional practice standards and competency requirements for registered nurse practice in Ontario. The
College of Nurses of Ontario’s ([CNO], 2014) “Competencies for Entry-Level Registered Nurse Practice” document itemizes “service to the public” as a key competency category that comes before “self-regulation” (p. 4). Likewise, as part of a nurses’ professional responsibility and accountability, his/her “primary duty is to the client” (p. 5) and s/he must “Demonstrate an understanding of the concept of public protection and the duty to provide and improve healthcare services” (p. 9). In this regard, the moral ideology of the CNO is enacted as duty service through the process or “interpellation or hailing . . . hey, you [nurse] there! [it is your duty]” (Foucault, 1984/1986, p. 190). Similarly, other Ideological State Apparatuses (ISA) such as hospitals and clinics, “where employers construct stereotypical notions of idealized workers in different class positions” (Batnitzky & McDowell as cited in Selberg, 2013, p. 25) perpetuates conditions of duty service within nursing practice. Batnizky and McDowell explained, that “this calling or naming in the workplace is in turn internalized by workers themselves so that they come to conform to or recognize themselves in the managerial naming” (p. 25). We see this in the Canadian Nurses Association’s ([CNA], 2017), “Code of Ethics” which serves as “the professional voice of over 139,000 registered nurses and nurse practitioners across Canada” (p. 2), the CNA considers “duty to provide care, [which] refers to a nurse’s professional obligation to provide persons receiving care” (p. 38), as one of its core ethical pillars.

By considering the ways that nursing practice ISAs (such as hospitals, clinics, professional nursing associations, and unions) dictate reality through interpellation, the way that care is textualized and enacted in nursing education may be examined through
their organizational structures and power influences of care and care of the self, both as a societal duty and social practice.

**Care of the self.**

In *The Care of the Self,* Michel Foucault (1984/1986) traced the practice of self-care (i.e., through the texts of the first centuries) and compared them “in close correlation with medical thought and practice” of the time (p.54). Foucault noted that both the *care of the self* and medicine centered on “the concept of ‘pathos’ . . . [which] applies to passion as well as to physical illness, to the distress of the body and the involuntary movement of the soul” (pp. 54). Over the years, however, professional care practice has negated the *self* from this equation. Instead, care is directed almost exclusively toward that of the *other.* Most notably, we see this occur in professional care practices that provide human healthcare and social services such as nursing, teaching, medicine, and law.

In the College of Nurses of Ontario (CNO’s) (2014) conceptual framework for organizing entry-level nurse competencies (refer to figure 1), care of the client (i.e., individual patients, their families, community groups or social networks) is at the forefront and heart of nursing education and practice. The CNO’s competency framework stipulates that “the primary duty [of the nurse] is to the client” (p. 5). Nowhere in the CNO’s (2014; 2002/2018) “Competency Framework” or “Professional Practice Standards” is self-care mentioned as an explicit requirement or guidance for nursing. The CNO’s (2002/2018) “Professional Practice Standards” only refers to a nurse’s *self* and *care* in limited terms as part of her/his accountability towards self-regulation as “performing self-assessment” (p. 4) and demonstrating “self-knowledge
Figure 1. Conceptual framework for entry-level registered nurse competency practice. [Digital image]. (2014). From “Competencies for entry-level registered nurse practice,” by the College of Nurses of Ontario.
(understanding one’s belief and values and being aware of how one’s behaviour affects others)” (p. 10). Care is only cited in the document in relation to a condition of service provision for others as in “advocating and promoting the best possible care for clients” (p. 4), “coordinating care for complex clients” (p. 10), and “promoting a philosophy of client-centered care” (p. 11). According to Foucault (1984/1986), care of the self is situated in the social practice of attending to one’s body, mind, and soul. Specifically, self-care was viewed as an imperative that circulated among a number of different doctrines . . . [that] took the form of an attitude, a mode of behavior; it became instilled in ways of living; it evolved into procedures, practices, and formulas that people reflected on, developed, perfected, and taught. It thus came to constitute a social practice, giving rise to relationships between individuals, to exchanges and communications, and at times even to institutions. (p. 44)

Foucault suggested that the practice of self-care could be examined through three key power positions. The first of these power positions is the individualistic attitude. He described this as the official recognition of the value that individuals assume according to the groups to which they belong and the institutions to which they are accountable; exemplified in the military aristocracy. The second power position Foucault identified was the positive valuation of private life. He equated this to the prominence accorded to family relationships and its arrangement of household and inherited responsibilities; exemplified in social/family class structures. The third power position Foucault identified was the intensity of the relations to self; exemplified in religious sects. He
defined this as how one sees oneself as both “an object of knowledge and as a field of action, to transform, correct, and purify oneself, and find salvation” (p. 42).

Foucault (1984/1986) explained that although these three positions were often interrelated (i.e., one may intensely value one’s private life while one’s individualism is also highly valued by the social groups to one belongs), they are neither “constant nor necessary” (p. 42). Foucault reasoned that,

One could find societies or social groups—military aristocracies [for example] . . . in which the individual is invited to assert his self-worth by means of actions that set him apart and enable him to win out over the others, without his having to attribute any great importance to his private life or to the relations of himself to himself. (pp. 42-43)

Likewise, other societies, such as the “bourgeois classes” may strongly value private life which is “carefully protected and organized . . . [and] forms the center of reference for behaviors” (p. 43), whereas

The Christian ascetic movement of the first centuries presented itself as an extremely strong accentuation of the relations of oneself to oneself . . . When it took the form of coenobitism, it manifested an explicit rejection of any individualism that might be inherent in the practice of reclusion. (p. 43)

Common among all three power facets is that the practice of caring for one’s self was something afforded to and “concerned only the social groups, very limited in number, that were bearers of culture and for whose members a techné tou biou [craft of life] could have a meaning and a reality” (p. 45). As such, the care and cultivation of one’s self became the cornerstone of an entire philosophical movement, one for which Epictetus (a
Greek Stoic philosopher who was born circa 50 AD, embraced as an entire way of life, not just an academic discipline (Foucault; Graver, 2008/2017).

From Epictetus’ teachings in “Discourses,” Foucault (1984/1986) traced the philosophy of care of the self as both a societal duty and social practice. This meant that persons privileged by their societal positions were duty-bound to self-care practice. For Epictetus, a person who had a tremendous influence on the development and practice of medicine as a discipline, the care of the self was “a privilege-duty, a gift-obligation that ensures our freedom while forcing us to take ourselves as the object of all our diligence” (p.47). Self-care practices included physical exercise to strengthen the body, reasoning debates to strengthen the mind, meditations to strengthen the soul, and discussions with confidants, friends, teachers, and guides to “reveal the state of one’s soul, solicit advice, [and/or] give advice” (p. 51). These activities took place in a mode and manner that was situated in communities of practices and “often took form within more or less institutionalized structures” (p. 51). In this sense, the duty and activities of caring for the self was not an isolated routine, but instead, a genuine social practice grounded in strict methodological and philosophical traditions. Foucault drew attention to this point, that “the most important aspects of this activity devoted to oneself: it constituted, not an exercise in solitude, but a true social practice” (p. 51), as a critical distinction between the enactment of self-care practices then (in Ancient times from its initial conception) and now. Even during the advent of Florence Nightingale’s (1820-1919) modern nursing practice, Foucault’s notion of self-care as a social practice can be compared differently to the enactment and textualization of self-care practices today.
Nightingale noted that the notion of “care duty” was not just afforded to the sick and wounded, but it was an essential self-care constituent in the practice of nursing. In two separate letters to Sir Harry Verney, Nightingale (as cited in McDonald, 2001) commented about the exhaustive state of her nurses and insisted upon the regiment of nurses’ duty hours. Nightingale wrote,

11 December [1882] . . . For several days the introduction of a day nurse has been inevitable. Julie is overworked. The night nurse ought always to be off duty by 10 a.m. or she cannot go on. (p. 359)

14 July 1886 . . . [Nurse] Davidson . . . and Nurse Taylor, both being thoroughly worn out, nothing having been done to help them. I know you kindly wish me to recapitulate: 1. Davidson on night duty when it is called a better night; Davidson gets up, that is, is called thirty times in one night!! This is the count. 2. The one who is on night duty ought to have at least from 2 p.m. to 10 p.m., for sleep, exercise, etc., to herself. (p. 597)

Compared to those who trained under the Nightingale discipline, today’s nurses are required to “study for a longer period of time, allowing for greater foundational knowledge in clinical practice, decision-making, critical thinking, leadership, research utilization, and resource management.” (Johnson, 2015, p. 3). These requirements place greater emphasis on a nurse’s autonomy and professional identity development as “expected performance or behaviour that reflects the professional attributes required in a given nursing role, situation, or practice setting.” (Johnson, 2015, p. 14). With greater professional autonomy, comes greater individual responsibility. As such, the practice of self-care has moved away from a community focus for holistic, healthy, and happy living
to one of individualized self-care plans and coping strategies in response to physical, mental, and emotional burnout (Care Research, 2017). In a study that attempted to illuminate the meaning of autonomy in nursing practice, researchers found that although professional autonomy,

- depends on certain conditions, such as the ability to make independent choices . . .
- a consequence of this freedom is that a professional has to be willing to take responsibility for one’s choices and actions and this includes an awareness of the beliefs and values within the choices made. (Skår, 2010, p. 2226)

If a nurse’s values are reflective of the professional practice standards to which s/he is accountable, then it follows that a nurse will take responsibility for those practice standards by enacting the values (as part of her/his professional identity) which have been textualized within those guiding documents. Where the terms self and care are limited in relation to a condition of service provision for others, one can start to understand how the professional focus of nursing has moved away from a societal care practice and instead towards individualized client care plans. Thus, a post-structural language frame that deconstructs the language binaries used to govern care and self-care in nursing, allows one to examine the ordered relationships between the concepts of caring for one’s self and caring for others, through the power dynamics and social structures of logocentrism and différance (Derrida, 1967/1997), ideology and interpellation, and care of the self (Foucault, 1984/1986). In turn, this positions us to think about the axiological, ontological, and textual dimensions in which self privileges other (or vice versa) based on the perceptions of one’s self in relation to others and others’ perceptions of one’s self. As such, in the following section, theories of identity and professional
identity formation in nursing are presented in connection to how changes in one’s self and self-identity (i.e., psycho-social, emotional, and physical well-being) may be examined through a literary lens.

**Identity Theory**

*Identity only becomes an issue when it is in crisis, when something assumed to be fixed, coherent and stable is displaced by the experience of doubt and uncertainty.*


The notion of self and self-identity is important when one seeks to understand who they are and where they belong in the world and the social order of humanity (Oyserman, 2001). Charles Horton Cooley (1902/2002), one of the early pioneers in social identity research, reasoned that the self could only be known through subjective experiences of emotions. He explained that a person’s self-concept is based on the perceptions of one’s self in relation to others and others’ perceptions of one’s self. He coined this phenomenon as *the looking glass self*, to illustrate the way that the self is perceived through the perception of others. Specifically, Cooley stated that,

As we see our face, figure, and dress in the glass, and are interested in them because they are ours, and pleased or otherwise with them according as they do or do not answer to what we should like them to be; so in imagination we perceive in another’s mind some thought of our appearance, manners, aims, deeds, character, friends, and so on, and are variously affected by it. A self-idea of this sort seems to have three principal elements: the imagination of our appearance to the other person; the imagination of his judgment of that appearance, and some sort of self-feeling, such as pride or mortification. . . The thing that moves us to pride or
shame is not the mere mechanical reflection of ourselves, but an imputed sentiment, the imagined effect of this reflection upon another’s mind. (p. 184)

Later, another key theorist in identity work, Mead (as cited in Epstein, 1973), extended Cooley’s work to include the notion of self-concept, a theoretical construct whereby a person’s view of one’s self and the world around him/her, is developed through a learned process. This learned behaviour of anticipating other’s reactions influences the way that a person develops one’s self-identity.

In his essay on the theory of the self-concept, Epstein (1973) referred to the product of identity formation as both a self-concept and a self-theory. Specifically, he stated that,

The self-concept is a self-theory. It is a theory that the individual has unwittingly constructed about himself as an experiencing, functioning individual, and it is part of a broader theory which he holds with respect to this entire range of significance experience. (p. 407)

By distinguishing the process (i.e., the self) and the product (i.e., self-concept) in identity theory, one’s identity may be seen as a dynamic process of self-reflection situated in the context and organization of interpersonal experiences and relationships. This forms the conceptual basis for which identity may be constructed, deconstructed, and reconstructed . . . where the concept of the self is understood to be evolutionary; something that is constantly in flux; something that is fluid, alive, and contextual (Zingsheim, 2010).

Some identity theorists, such as Kelly (as cited in Epstein, 1973), did not accept the notion of a self-concept. Kelly stated that
the value of distinction between self and nonself can be surmised in a universal
higher order postulate in an individual’s overall conceptual system is that the data
of experience can be organized into a self-system and a world system. (p. 408)
Kelly saw no logical necessity to entertain the development of a self-concept because his
basis for understanding the self and the non-self was derived from a singular
interpretation of the world. Kelly summarized his theory into three main points:

For one, to act within a world of shared reality, it is necessary to distinguish what
is subjective from what is common experience. Second, the distinction between
self and nonself is useful for the individual to exercise control of his behavior.
Third, for humans to live harmoniously in social communities, it is necessary to
have a concept of responsibility, and such a concept would be meaningless
without a distinction between self and nonself. (Kelly, as cited in Epstein, 1973, p.
408)

Epstein (1973) pointed out gaps in Kelly’s thinking, specifically as it related to
the value, centrality, and role of emotion in the development of a self-theory. Epstein
reasoned that there are two ways in which emotion and cognition are linked to the
development of self-concept. The first relates to the supposition that a person’s emotions
are linked to events, and events are something that a person has interpreted, and those
interpretations, in turn, becomes part of a person’s experience. These events and
experiences, whether positive, negative, or even neutral, are assumed to have influenced
the person’s notion of self. The second way Epstein linked emotion and cognition to the
development of self-concept is through the supposition that a person’s emotions are
connected to important aspects, or schema, by which a person constructs one’s self.
Epstein illustrated this point in the way that a person feels fear or anger in response to an event or experiences that cause oneself to feel threatened. This experience of feeling threatened shapes a person’s self-theory. This led Epstein to conclude that if emotions are linked to the core ways that a person thinks about oneself, then by understanding a person’s emotional temperament, it is conceivable to reconstruct a person’s self-identity theory.

**Social and Cultural Contexts of Identity Theory**

The social and cultural context of self-identity theory are linked to the way one perceives one’s self and how people classify themselves (and others) within a group or community (Ashforth & Mael, 1989). Typically, categories are demarcated by ideal attributes garnered from its members. Ashforth and Mael reasoned that key factors associated with the social identification process, “stems from the categorization of individuals, the distinctiveness and prestige of the group, the salience of outgroups, and the factors that traditionally are associated with group formation” (p. 20). However, Ashforth and Mael also reasoned that even though many social groups are categorical (e.g., nurse-in-training, registered nurse, well, unwell), the degree to which a person associates or identifies with different groups is dependent on a variety of factors. Ashforth and Mael listed four factors or principles, which influence the social identification process.

First, “identification is viewed as a perceptual cognitive construct that is not necessarily associated with any specific behaviors or affective states” (Ashforth & Mael, 1989, p. 21). For example, one does not need to disburse energy toward the group’s goals or group’s identity, but rather, one only needs to consider oneself as emotionally
and mentally linked with the group. Secondly, Ashforth and Mael indicated that the social identification process allows one to personally experience the achievements or disappointments of that group. In this example, social identification is sustained in circumstances that involve “great loss or suffering, missed potential benefits, and even expected failure.” (p. 21). The third and fourth principles that influence the social identification process reported by Ashforth and Mael, relates to its distinction from internationalization (i.e., a process whereby one assumes the ideals, attitudes, and behaviours of a group), and its association with “a person (e.g., one’s father, football hero) or a reciprocal role relationship (e.g., husband-wife, nurse-patient) inasmuch as one partly defines oneself in terms of a social referent” (p. 21). Ashforth and Mael noted that although certain principles and mindsets may be connected with members of a specific social category,

acceptance of the category as a definition of self does not necessarily mean acceptance of those values and attitudes. An individual may define herself in terms of the organization she works for, yet she can disagree with the prevailing values, strategy, system of authority, and so on. (p. 21)

In nursing, the social and contextual factors of the work environment can have a tremendous influence on a nurse’s professional identity. Likewise, in nursing education, the connection between theory and practice is an important issue that has a tremendous influence on the way nursing students develop into professional nurse practitioners (Woods, Cashin, & Stockhausen, 2016).
Professional Identity in Nursing Education

To provide medical educators with a basis for teaching and evaluating professional practice behaviours, Canadian medical educators developed the following working definition for a “profession” and the roles of its members,

Profession: An occupation whose core element is work based on the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society. (Cruess, Johnston, & Cruess, 2004, p. 75)

Professional identity, therefore, is the identity one constructs about one’s self in relation to a group of professionals and professional work responsibilities. Key components to the development of professional identity are based on a person’s “position within society,” “interactions with others,” and their “interpretations of experiences” (Sutherland as cited in Johnson, Cowin, Wilson, & Young, 2012, p. 563).

Although it is a dynamic and iterative process, a nurse’s professional identity typically develops during the time s/he enters nursing school until the time s/he moves into professional practice (Bayne-Smith, Mizrahi, Korazim-Kőrösy, & Garcia, 2014;
Johnson, Cowin, Wilson, & Young, 2012; Marañón & Pera, 2015; Woods, Cashin, & Stockhausen, 2016). According to Marañón & Pera (2015) “during this period, they [nursing students] learn the norms, values, behaviors, attitudes, and culture of the profession to which they aspire to belong” (p. 860). Individual identity characteristics (such as gender, ethnicity, ability, education, life experiences, and one’s social, cultural and political beliefs), relational identity characteristics (those shaped through the influence of significant others such as family, friends, colleagues, peers, and mentors) and collective identity characteristics (those shaped by the social elements of the groups in which one belongs or wishes to join) form the construction domains of professional identity (Jennings, 2009; Marañón & Pera).

While nursing college is a transitory time during which nurses heavily focus their attention toward developing technical nursing expertise, professional identity socialization amongst nursing students also occurs (Marañón & Pera, 2015). Some researchers, such as Cohen (as cited in Marañón & Pera, 2015) have suggested that nurses develop their professional identity through a four-stage process.

The first stage consists mainly of basic theoretical learning. In the second phase, the students begin to feel able to question what they learn and to compare information, norms and values. In the third phase, the students must find a model of their professional role that meets both their personal needs and the demands of their profession. In the fourth and final phase, the students feel comfortable with their professional role, which forms part of their self-concept. (p. 860)

Instances where practice behaviours (e.g., a workplace system that stipulates patient care based on a set number of hours) do not reflect theory (e.g., nurses provide care based on
patients’ needs), or tensions exist between students’ perceived expectations/imagined role of nursing professionals (e.g. strong, committed, and compassionate) to that of reality (e.g. nurses who are burnt out and fatigued), identity crisis may occur.

**Identity crisis.**

Identity crisis experienced by nursing students and entry-level nurses can reinforce feelings of fear, failure, lack of self-confidence, and professional self-doubt. (Chachula, Myrick, & Yonge, 2015; Michalec, Diefenbeck, & Mahoney, 2013; Schrijver, 2016). In some cases, workplace cultures may hamper the development of nursing professional identity to such an extent that nurses leave the professional altogether (Hensel & Laux, 2014). In fact, this issue is so prevalent that the Canadian Federation of Nurses Union (CFNU) and the Canadian Nurses Association (CNA) have coined it as “moral distress.” In the following quotation taken the CFNU’s 2012 Report, “Realities from frontline nurses,” the impact of moral distress is described:

“I worked the unit for four months before quitting. Looking back, I realize I was having ethical/moral distress in not being able to provide nursing care at the level my patients deserved. I was going home feeling horrible that half of my patients didn’t get bathed that day. (Sidney, Saskatchewan).” (p. 16)

Since nurses are twice as likely to experience illness and disability due to excessive workload stress and occupational burnout compared to all other employment sectors in Canada (CFNU, 2012), I believe it is an ethical imperative that nursing education programs equip students with the knowledge and skills to successfully mitigate these risks. Although many nursing programs attempt to do this through professional development practices, often, this lacks sufficient emphasis on the emotional and
relational elements of professional identity formation (Goodolf, 2018). Though little research in nursing education has been done to explore this deficiency, we know that in other professional training programs such as pre-service teacher education, those that lack “systematic efforts to provide pre-service teachers with a realistic understanding of teachers’ emotional experiences and developmental stages,” (Hong, 2010, p. 1540) have higher rates of pre-service and early career teachers leaving the profession. From Stock, Sameshima, and Slingerland’s (2016) work in pre-service teacher identity construction, we also know that,

Developing a professional identity is an ongoing process as identities are constantly navigated through interactions, in context, and over time . . . Further, identity formation involves an emotional element as meanings are developed through relationship with culture and events. . . . Thus, although many teacher education programs may already include identity development programming, unless teacher educators are able to encourage PSTs’ personal connections to teaching philosophies, little change will occur. (pp, 491-492)

**Identity change theory.**

Some scholars suggest that identity change is linked to the self-concept theory (Bailey, 2003; Bandura, 1977; Epstein, 1973), whereby the “measurable concretes about what one does (e.g. achieving work products, like sports records), measurable aspects of how one appears (e.g. one’s body proportions) and material things one has” (Bailey, p. 383) are externally constructed. Bailey further proposed that “the assessments placed on these [identity] qualities may be significantly influenced by the outsiders in one’s
immediate environment and by society at large” (p. 383). This theory is significant to the way that a person learns to view oneself in the experience of identity crisis and change.

Learning to understand the constructs of one’s identity, and one’s changing identity, involves critical self-reflection and contextualization of meaning underlying the assumptions grounding one’s beliefs, values, and feelings (Mezirow, 1990). Adapting to changing identity goals through the process of critical self-reflection is both the product and process of transformative learning. As identity constructs are deconstructed then reconstructed, identity change occurs, and transformative learning takes place (Barclay-Goddard, King, Dubouloz, & Schwartz, 2012). Gregg, Sedikides, and Gebauer (as cited in Schwartz, Luyckx, & Vignoles, 2011) compare this process to how people do not only construe themselves as they are or were, but they also construe themselves as how they might be or might have been. Such “possible selves,” whether hypothetical or counterfactual, are as much a part of the psychological landscape as the actual self is: they furnish the framework for interpreting and evaluating it. Complex comparisons ensue, with information drawn from the social world, personal introspections, and theories about abilities. (pp. 306-307)

Through the construct of identity motives (i.e., possible selves), individuals can learn to understand themselves “in pursuit of a desired identity, or in flight from a feared one” (p. 309). This may be supported through an ethics of care. Like pre-service teachers, nursing students’ professional identities are predominantly influenced by societal and cultural expectations (Hall, 2005; Maginnis, 2018). The way nursing students are taught to examine identity change experiences, as triggered by critical moments and sources of stress (precursors to burnout) in their nursing education, is inherently linked to the way
they see and value themselves and their colleagues, in a professional and self-caring light (Hensel & Laux, 2014).

**Narrative identity.**

One way to examine identity change is to understand how individuals form an identity by piecing their life experiences into an evolving internalized story of the self that gives the individual a sense of wholeness and life purpose (McAdams & McLean, 2013). Thus, a narrative identity is, “a person’s internalized and evolving life story, integrating the reconstructed past and imagined future to provide life with some degree of unity and purpose” (McAdams & McLean, p. 233). Typically, approaches in the study of narrative identity focus on the identification and formulation of an event series that constitute a chronology of past, present, and future (Torn, 2011). This involves the systematic analysis of narrative data organized and categorized into patterns and themes which in turn, are reported according to the temporality of the storyteller’s thoughts, behaviours, and actions through time (Wisdom, Bruce, Saedi, Weis, & Green, 2008).

Described metaphorically as one of the three commonplaces of narrative inquiry (Connelly & Clandinin, 2006), this type of narrative chronology is structured so that “events under study are in temporal transition... with a past, a present, and a future... [and] to give a narrative explanation, one needs to know the temporal history; that is, what happened the day before, the day before that, the month before that, and so forth (p. 480). The process of identity change, however, can often present as a disorienting dilemma. When this happens, traditional linear narratives may no longer be possible. As such, an alternate way to study narrative identity, especially in the process of identity change, is to interpret how the self holds existence in time and space (Bakhtin, 1981;
This may be achieved by understanding the performativity of narrative not in the way that language is used to communicate ideas, but the way in which language (as text and visual art) perform and embody ideas in the construction of identity (Butler, 1990; Stock, Sameshima, & Slingerland, 2016, 2016; Spry, 2010).

Metaphors and imagery.

The English Oxford Living Dictionary (n.d.) defines metaphor as “a figure of speech in which a word or phrase is applied to an object or action to which it is not literally applicable” and imagery as “visually descriptive or figurative language, especially in a literary work.” The use of both these literary devices is important in narrative identity work, especially in the study of identity change experiences, as often “narrative of transformative crisis . . . involves a difficult or traumatic episode and a period of self-questioning out of which a person emerges abler and more emotionally mature than before” (Robinson & Smith, 2006, p. 1). Metaphors and imagery, unlike semantic text, can uncover the unspoken assumptions people use to make sense of their experiences in its livingness, a term Ricoeur (1975) used to explain how meaning is constructed from “sense to reference.” Different from reflective thought described as, “a meaning-making process that moves a learner from one experience into the next with a deeper understanding of its relationship and with connections to other experiences and ideas . . . [as]a systematic, rigorous, [and] disciplined way of thinking” (Rogers, 2002, p. 845), metaphors and imagery can be used to narrate misunderstood or potentially disorienting phenomena (such as identity crisis) without the luxury of hindsight or reflection.
In a study that examined how visual metaphors can be used to understand identity constructs, Clarke and Holt (2017), showed that metaphors ground the creation of identity by bringing concepts from different, better known domains into conversation with the ambiguous experience(s) of being . . . Metaphors influence the connections we make but also the connections we don’t make, and by emphasizing certain interpretations (p. 477).

Thinking about metaphors apart from its text and imagery apart from its visual representation, metaphors, and imagery are artistic expressions of thought, understanding, and dialogue. This allows both the person[s] telling and the person[s] listening, to move beyond an unreflective use of dominant [language] . . . that potentially conceal[s] as much as they [it] reveal[s] . . . [by] draw[ing] upon more accessible and familiar areas of experience and, . . . convey[ing] it in a matter] what would otherwise be difficult to articulate (Clarke & Holt, 2017, p. 478)

Furthermore, the use of metaphors and imagery encompasses an approach to thinking that shapes how we identify with and understand our world (Morgan, as cited in Clarke & Holt). According to Clarke and Holt,

Metaphors transcend language and operate at structuring levels of action and thinking . . . [which allows one to] develop understandings of the complex and vague through the filter of more tangible experiences. In fact, ‘as soon as one gets away from concrete physical experience and starts talking about abstractions or emotions, metaphorical understanding is the norm’ (Lakoff, 1993, p. 205). (p. 478)
Just as metaphors and imagery can help persons communicate and understand ideas, relationships, and experiences, they can also detract from other viewpoints or interpretations. Without further interrogation, people’s ability to consider an alternate perspective may be blinded, blocked, or put to the background (Weick, as cited in Clarke & Holt, 2017). This subjectivity is characteristic to what has been described as “metaphorical understanding . . . [a way that ] introduce[s] but also obscure[s] the complex and polyphonic nature of experience” (p. 479). It is important, therefore, to critically appraise the meanings behind narrative metaphors and imagery, in parallel to the overall hermeneutics of the phenomena under investigation.

**Hegemonic identity.**

By deconstructing narratives through a post-structural lens (i.e., interpreting text through the language constructs of binary opposites, ideology, interpellation, and performativity), one can understand how pervasive societal norms are reflected in the language used to construct hegemonic identities. Hegemony, as described by Gramsci (cited in Keisling, 2006), “involves maintaining dominant social positions through less obvious but more basic means than direct coercion: for example, by controlling the basic ideologies in society rather than ruling by force” (p. 261).

Although some people in hegemonic positions may “not always feel powerful, and they, in fact, may not directly dominate anyone,” (Keilsling, 2006, p. 261), Butler (1990) explained how performativity and the hegemony of language play out. She described the flaws in the use of language to express views that may be perceived as distorted and ostracized. Butler states,
Neither grammar nor style are politically neutral. Learning the rules that govern intelligible speech is an inculcation into normalized language, where the price of not conforming is the loss of intelligibility itself. It would be a mistake to think that received grammar is the best vehicle for expressing radical views, given the constraints that grammar imposes upon thought, indeed, upon the thinkable itself. But formulations that twist grammar or that implicitly call into question the subject-verb requirements of propositional sense are clearly irritating for some. They produce more work for their readers, and sometimes their readers are offended by such demands . . . The demand for lucidity forgets the ruses that mortar the ostensibly “clear” view. (pp. xix-xx)

Knowing how one’s identity may be impacted by hegemonic discourse is an important consideration for nursing students. As “nurses are shifting their attention away from institutionalized experiences of illness to a focus on clients [and] health needs in the broader context of their lives . . . they should be aware of how power affects their interactions” (Gregory, Harrowing, Lee, Doolittle, & O'Sullivan, 2010, p. 1).

The following section emphasizes the emotional and relational elements of professional care practice and its power dynamics, as a pedagogical framework to understand identity formation in developing relationships, morality, and a clear sense of self. I introduce the pedagogy of care, through the works of Carol Gilligan (1982/1993) and Nel Noddings (1984/2013), and question whether this theory is evident in modern nursing practice.

The Pedagogy of Care

Although the early works of care theorists Carol Gilligan (1982/1993) and Nel Noddings (1984/2013) gendered care as “feminine,” a more contemporary interpretation of care ethics
draws awareness to the established frameworks and activities that continue to cultivate unfairness and discrimination. A report submitted to the World Medical Association on behalf of the International Network on Feminist Approaches to Bioethics described the ethics of care as one that “calls for directing our attention to features of the social and institutional context related to the research enterprise, including contextual features that may perpetuate patterns of inequality or power imbalance” (Eckenwiler, Feinholz, Ells, & Schonfeld, 2008, p. 162). An ethics of care transcends beyond gender equality; through an examination of relational dynamics, it extends the hand of social justice and dignity to all those whose voices have been overlooked or silenced. Applying care ethics to self-care curriculum in professional care practice education programs such as nursing, requires careful forethought into the relational and developmental structure of care, as a theory centered on relationships, emotions, and responsibility for others.

**In a Different Voice**

In her study of moral development, Gilligan (1982/1993) discovered that women fostered a different sense of morality, compared to men, as awareness of their selves unfolded. In “*In A Different Voice,*” Gilligan highlighted deficiencies with moral decision making based solely on an ethics of justice, (which privileged the male voice over that of the female), and called attention to the multiplicity and difference of voice within moral decision making as a central tenet to care ethics theory (Shapiro & Stefkovich, 2005). This thinking is evident in Gilligan’s research about women’s abortion decisions.

When the development of birth control and abortive surgical procedures came into common practice during the 1960s, women had control over their reproductive health. This resulted in a dilemma of choice, a moral conflict which compelled women to
favour care as a choice between one's self versus that of others [or potential others].

Specifically, Gilligan (1982/1993) noted that,

while society may affirm publicly the woman’s right to choose for herself, the
exercise of such choice brings her privately into conflict with the conventions of
femininity, particularly the moral equation of goodness with self-sacrifice . . . The
conflict between self and other thus constitutes the central moral problem for
women. . . The “good woman” masks assertion in evasion, denying responsibility
by claiming only to meet the needs of others, while the “bad woman” forgoes or
renounces the commitments that bind her in self-deception and betrayal. It is
precisely this dilemma-the conflict between compassion and autonomy, between
virtue and power—which the feminine voice struggles to resolve in its effort to
reclaim the self and to solve the moral problem in such a way that no one is hurt.
(pp. 70-71)

When Gilligan interviewed participants to understand how these moral dilemmas were
resolved, she observed that women’s constructs of the problem were not based on a
system of rules, rather they were based on “care and responsibility in relationships” (p.
73). What is interesting in Gilligan’s work is how morality was interpellated by her study
participants. Participants used a particular “moral language,” organized into binary
opposites of “selfishness” and “responsibility” when asked to describe the ethical
reasoning behind their abortion decisions. By studying the patterns of language used by
her participants, Gilligan illustrated a three-phase progression in the development of care
ethics. In the first phase, Gillian explained that
an initial focus on caring for the self is to ensure survival. This is followed by a transitional phase in which “caring for the self” is criticized as “selfish.” This criticism signals a new understanding of the connection between self and others which is articulated by the concept of responsibility . . . [and leads to] the second perspective. At this point, the good is equated with caring for others. However, when only others are legitimized as the recipients of the woman’s care, the exclusion of herself gives rise to problems in relationships . . . [which] lead[s] to a reconsideration of relationships to sort out the confusion between self-sacrifice and care inherent in the conventions of feminine goodness. The third perspective focuses on the dynamics of relationships and dissipates the tension between selfishness and responsibility through a new understanding of the interconnection between other and self. (p. 74)

Although the explicit language used by Gilligan’s participants in the context of abortion decisions equated care of the self to that of selfishness and care of the other to that of responsibility, these words have relevance in the ethical care relationships in professional care practices such as nursing. For example, in the College of Nurses of Ontario’s (“CNO,” 2002/2018) “Professional Practice Standards” under “Relationship,” a nurse demonstrates adherence to the standard by “ensuring clients’ need remain the focus of the nurse-client relationships [and] ensuring that her/his personal needs are met outside of the therapeutic nurse-client relationship” (p. 11). Missing from this language is the concept of self and the care of the self in recognition, response, and relationship in the professional care of others and with others.
Caring: A Relational Approach to Ethics and Moral Education

In “Caring: A Relational Approach to Ethics & Moral Education,” Noddings (1984/2013) presented a moral theory of how “we should meet and treat one another—with how to establish, maintain, and enhance caring relations” (p. xiv) as ethics of care. At the outset of her theory, Nodding introduced the notions of the “ethical ideal” and the “ethical self” to acknowledge and elucidate the asymmetry and reciprocity in caring. She described how these two selves co-exist in the caring relationship where “the cared-for depends upon the one-caring. But the one-caring is also oddly dependent upon the cared-for” (p. 48). This mutual dependence exists because of the “fundamental recognition of relatedness; that which connects me [the self] naturally to the other, reconnects me [the self] through the other to myself” (p. 49). The ethical self (i.e., the self that “is an active relation between my actual self and a vision of my ideal self”), allows one to care for him/herself through the caring of others. In this way, the self and others do not exist as binary opposites, but instead, they subsist as continuums of the same spectrum. In other words, caring occurs with others. Nodding explained:

Since caring is a relation, an ethic built on it is naturally other-regarding. Since I am [the self is] defined in relation, I do not [the self does not] sacrifice myself [oneself] when I [he/she] move[s] toward the other as one-caring. Caring is, thus, both self-serving and other-serving. (p. 99)

Noddings likened this idea to the necessity of altruism in the survival of the human species as described by Willard Gaylin, Clinical Professor of Psychiatry and Co-Founder of the Hasting Institute—the first bioethics research institute of its kind “to address fundamental ethical issues in health, healthcare, life sciences research and the
environment affecting individuals, communities, and societies” (“The Hastings Institute”, n.d.). Gaylin (as cited in Noddings) stated, “If one’s frame of reference focuses on the individual, caring seems self-sacrificing. But if the focus is on the group, on the species, it is the ultimate self-serving” (p. 99). Practically, this interpretation of care ethics makes sense when considering care as an ontological necessity of human existence and as an ontology for professional care practice. The ease or difficulty, however, of implementing care ethics into professional care practice is largely dependent on how care practitioners are recognized as “persons with human needs and limitations” within their professional practice communities (Jennings, 2009).

Compare Nodding’s (1984/2013) notion of care ethics to the realities from frontline nurses as described in the Canadian Federation of Nurses Union (2012) “Nursing Workload and Patient Care” Report. Whereas Nodding described the one caring as having to properly pays heed to her own condition . . . not need[ing] to hatch out elaborate excuses to give herself rest, or to seek congenial companionship, or to find joy in personal work . . . To go on sacrificing bitterly, grudgingly, is not to be one-caring and, when she finds this happening, she properly but considerately withholds for repairs. When she is prevented by circumstances from doing this, she may still recognize what is occurring and make heroic efforts to sustain herself as one-caring. Some are stronger than others, but each has her breaking point. (p. 105) realities from frontline nurses as described as follows:

Over a period of one year, I gained forty pounds and started having trouble getting to work on time. On one occasion, I was reprimanded in front of other
staff for being late. Some weeks later, at a time of family crisis, I called in to request a personal leave day, and I felt my integrity was being questioned by the manager. That day I submitted a request to give up my FTE [full-time employment status] and revert to a casual position (Francis, Alberta). (p. 23)

There exists a gap between the theory and practice of care ethics in the nursing profession. The consequence of this gap—burnout, emotional exhaustion, depersonalization and “disengagement or lack of empathy on the part of care-giving professionals” (Locke & Lees, 2017, p. 147) has the potential to negatively impact the quality of caregiving and the very vocation of professional care practice in and of itself. In consideration of this interplay, and how it translates into professional education and practice (i.e., nurses and nursing students work and study in a reciprocally dynamic role in which their health and well-being directly impact their professional competence and vice versa) as a first step towards developing nursing self-care curricula that effectively prepare its students for successful and sustainable employment, it is important to understand the notion and phenomenon of self-care in professional nursing education programs, which is the purpose of this study. The following section (chapter three) therefore details the methodology and methods of this study.
CHAPTER THREE: METHODOLOGY AND PROCEDURES

Through stories, we seek to make sense of our past, present, and future experiences. Experiences in the context of social, cultural, and political surroundings, stories, like streams, carve the topography from which meaning is made, and new meaning flows. (Docherty-Skippen & Brown, 2017, p. 56)

This chapter presents the research methodology and study design considerations I used to explore the phenomenon and notion of self-care as a professional competency in nursing education. Included in this chapter are the following key sections: 1) the philosophical orientation and methodological framework guiding this study, 2) the research design and data interpretation methods used in this study, and 3) the ethical considerations involved in the conduct of this research.

Philosophical Orientation and Methodological Framework

The questions I posed in this research study were designed to explore nursing faculty’s experiences of self-care as a professional competency in nursing education. The philosophical orientation and methodological framework guiding this research are rooted in the branch of qualitative research known as hermeneutic phenomenology. According to van Manen (1982), “Phenomenology is not propositional discourse. There is no systematic argument, no sequence of propositions that we have to follow to arrive at a conclusion, a generalization, or a truth statement because that would be to see theorizing itself as method” (p. 298). This makes it a practical method to capture potentially disorienting or distressing lived human experiences (i.e., experiences in which participants recall incidents where self-care practices were overlooked, neglected, or ill-managed).
Like phenomenology, hermeneutic phenomenology explores *lived experiences* to create meaning and understanding (Wilson & Hutchinson, 1991). First introduced by Martin Heidegger (1889-1976), as both a philosophy and research method (Kafle, 2011), hermeneutic phenomenology “does not seek to describe experiences as inanimate or objective, but rather, it provides direction towards interpretation and “understanding something as living in the moment in its livingness” (van Manen, Higgins, & van der Riet, 2016, p. 6). This involves textual interpretation, to understand meaning as a whole, through the development of themes expressed in “everyday language as close to the lived experience as possible” (Lindseth & Norberg, 2004, p. 151).

Conceptually, hermeneutic phenomenology differs from traditional phenomenology, otherwise referred to as *pure* or *transcendental phenomenology*, in that it posits meaning and understanding as something situated or subjective. Where traditional phenomenology seeks to explore the essence of beings, by “bracket[ing] out the outer world as well as individual biases in order to successfully achieve contact with essences” (Laverty, 2003, p. 24), hermeneutic phenomenology seeks to explore “*Dasein*”, a Heideggerian term that means, “the mode of being human or the situated meaning of a human in the world” (Laverty, 2003, p. 24).

Significant health research, especially in the area of mental health and emotional wellness, has used hermeneutic phenomenology as a methodology to explore hidden, misunderstood, and even taboo lived human experiences surrounding issues of shame, loss, fear, stigma, inclusion, ethics, and abuse, (Adams, 2008; Chang & Horrock, 2008; Johnson, 1998; Jones, 2003; McCann & Clark, 2004; Nicki, 2001; Wilde, 2003; Woodgate, 2006). Key characteristics of hermeneutic phenomenology have been described by Gadamer (cited in Kinsella, 2006) as it seeks understanding, interpretation is situated, understanding is mediated by both language and history, inquiry takes the form of conversation, and it is comfortable with ambiguity. The hermeneutic undertaking, therefore, is to elucidate the interpretive conditions centered on the contextual meaning of experiences. Central to this process is the researchers’
ability to “give considerable thought to their own experience and to explicitly claim the ways in which their position or experience relates to the issues being researched” (Laverty, 2003). As such, hermeneutic researchers position themselves within the interpretative process. In chapter one, I have described my positioning within this query as a caregiver, researcher, and educator who works in a care-giving profession.

**Study Design**

To explore the notion and phenomenon of self-care (i.e., the intentional way one takes care of one’s self) as a professional competency in caring for others, in nursing education, I used a qualitative hermeneutic phenomenological design for this study.

**Research Population/Participant Selection.**

The population of interest for this research study is nursing faculty who have insight into the way that self-care is articulated, enacted, taught, and assessed as a professional competency in nursing education. Eight nursing faculty from seven Ontario nursing education programs participated in this study. Demographics for this study population have been presented (refer to table 1). Two participants were male, and the rest were female. Participants’ experience practicing nursing varied. Five participants had between five and ten years of nursing experience, one participant had between ten and 20 years, and two participants had more than 20 years of nursing practice experience. Participants’ experience teaching in a nursing faculty also varied. Three participants had less than five years of teaching experience, three participants had between five to ten years, one participant had between ten and 20 years, and one participant had more than 20 years of teaching experience. Participants’ practice locations and areas of nursing specialty varied also. Two participants practiced in rural areas, and the rest practiced in urban areas. Two participants worked in palliative and community care nursing, one
Table 1.

Participant demographics.

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Gender</th>
<th>Practice/Teaching Location</th>
<th>Area of Nursing Specialty</th>
<th>Nursing Experience (# Years)</th>
<th>Teaching Experience (# Years)</th>
<th>Interview Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbey</td>
<td>Female</td>
<td>Urban</td>
<td>Labour &amp; Delivery</td>
<td>5 to 10 years</td>
<td>Less than 5 years</td>
<td>face-to-face</td>
</tr>
<tr>
<td>Rose</td>
<td>Female</td>
<td>Urban</td>
<td>Palliative &amp; Community Care</td>
<td>More than 20 years</td>
<td>More than 20 years</td>
<td>video</td>
</tr>
<tr>
<td>Dan</td>
<td>Male</td>
<td>Urban</td>
<td>Nephrology</td>
<td>More than 20 years</td>
<td>10 to 20 years</td>
<td>face-to-face</td>
</tr>
<tr>
<td>Collette</td>
<td>Female</td>
<td>Rural</td>
<td>Primary Care</td>
<td>5 to 10 years</td>
<td>Less than 5 years</td>
<td>telephone</td>
</tr>
<tr>
<td>Laura</td>
<td>Female</td>
<td>Urban</td>
<td>Gerontology</td>
<td>10 to 20 years</td>
<td>5 to 10 years</td>
<td>face-to-face</td>
</tr>
<tr>
<td>Shannon</td>
<td>Female</td>
<td>Rural</td>
<td>Emergency &amp; Critical Care</td>
<td>5 to 10 years</td>
<td>Less than 5 years</td>
<td>video</td>
</tr>
<tr>
<td>Matt</td>
<td>Male</td>
<td>Urban</td>
<td>Critical Care</td>
<td>5 to 10 years</td>
<td>5 to 10 years</td>
<td>telephone</td>
</tr>
<tr>
<td>Sandi</td>
<td>Female</td>
<td>Urban</td>
<td>Palliative &amp; Community Care</td>
<td>5 to 10 years</td>
<td>5 to 10 years</td>
<td>face-to-face</td>
</tr>
</tbody>
</table>
participant worked in critical care nursing, one participant worked in emergency and
critical care nursing, one participant worked in labour and delivery nursing, one
participant worked in nephrology, one participant worked in primary care, and one
participant worked in gerontology. Four interviews were conducted face-to-face, two
were conducted via video-conference, and two were conducted over the telephone.

Participants were selected using a purposeful snowball sampling technique to seek
phenomenological variation based on “a-typical, or, in some way, exemplary
information-rich cases” (Sandelowski, 1995, p. 180). Snowball sampling is a non-
statistical participant recruitment process that requires existing research participants to
recruit new participants from among their established networks of acquaintances.

Typically,

the snowball sampling outreach strategy finds individuals, who have the desired
characteristics, and uses that person’s social networks to recruit similar subjects,
in a multi-stage process. After the initial source helps to recruit respondents, the
respondents then recruit others themselves, starting a process analogous to a
snowball rolling down a hill. Thus, the semi-self-directed, chain-referral,
recruiting mechanism is able to reach the hard-to-reach target group in a more
pragmatic and culturally competent way. (Sadler, Lee, Lim, & Fullerton, 2011)

Although it has been suggested that snowball sampling can lead to potential biases in
participant recruitment, its benefits are considerable. According to Noy (2008),
“snowball sampling relies on and partakes in the dynamics of natural and organic social
networks. . . [and] when viewed holistically, . . . [it] can potentially generate an organic
and ‘thick’ type of knowledge” (pp. 329-335). Beginning with a few key contacts I knew
from Brock’s Department of Nursing, through an REB approved (Brock University REB File # 17-425-BROWN) letter of invitation, I asked those individuals to invite other members from their community of practice (with similar experience and insight) to contact me to participate in this study. In turn, “new” participants invited others to participate in this study. The sample size for this study, n=8, is in line with what has been recommended by Morse (as cited in Sandelowski). Morse has suggested to include about six participants “for phenomenological studies directed toward discerning the essence of experiences” (p. 182).

**Data Collection.**

Interview transcripts and field notes served as primary data sources for this study. Secondary data, in the form of interpretive texts and photographic images, were derived through a reiterative hermeneutic interchange of writing and textual interpretation, moving between the participants’ spoken words, written transcripts, field notes, recollections, and critical reflections. The primary data collection instrument used for this study was a semi-structured interview guide (refer to Appendix B). Questions were designed to collect in-depth, lived experiential responses related to the phenomena of self-care and professionalism in nursing education. Questions for the interview guide were adapted from those used by Warren et al. (2014) in a study that examined the educational strategies for professionalism as part of the Royal College of Physicians and Surgeons of Canada CanMEDS competency framework. Before study commencement, interview questions were reviewed for clarity, relevance, and ease of completion by a faculty member of Brock University’s Department of Nursing who did not participate in the study.
All interviews started in the same manner. Together, the participants and I reviewed the REB approved study invitation letter and informed consent documents. All participants were comfortable and willing to participate in the study. Participants did not ask me any questions related to the study, before or after the interviews were conducted. Interviews were approximately 60 minutes and took one of three forms, depending on participants’ preference and geographic location: 1) face-to-face, 2) videoconference or 3) teleconference. All interviews were audio-recorded then transcribed, by me, using NVivo software (version 12). Textualization of the non-verbal elements of the interview conversations was done using grammar symbols and conventions (refer to table 2). The conventions itemized in table 3 were adapted from the conversational analysis transcription work of Gumperz & Berenz (1993), Atkinson, Heritage, & Oatley (1984), and Langford (1994). After the interviews were transcribed, I sent participants electronic transcripts of their interviews. All participants confirmed, through email, that the transcripts they reviewed were accurate accounts of our conversations, and that they were comfortable with me using those transcripts as research data.

**Data Interpretation.**

Data was analyzed through an interpretive process which “aimed at generating a deeper understanding of the topic by facilitating a fusion of the world views of both participant and researcher” (Smith, 1998, p. 213). Similar to the interpretive method described by Docherty-Skippen and Brown (2017) as the “metaphoric stages of narrative paralleled thematically according to the experience and depth of delving beneath the surface in narrative reconceptualization,” (p. 67), the data organization and interpretation method I used in this study transformed my existing knowledge into new knowledge.
Table 2.

Notation table of transcription codes.

<table>
<thead>
<tr>
<th>Punctuation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>:</td>
<td>Colon indicates a stretched sound and is placed after the stretched vowel; the more stretched the sound, additional colons (‘:’s) are used e.g., Speaker 1: what ha:ppened to you; e.g., Speaker 1: i’m so:::rry;</td>
</tr>
<tr>
<td>↑ ↓</td>
<td>Upward arrow indicates a marked rise in pitch; Downward arrow indicates a marked lowering of pitch;</td>
</tr>
<tr>
<td>_</td>
<td>Underscore indicates emphasis; e.g., Speaker 1: finally they gave me my driver’s licence;</td>
</tr>
<tr>
<td>CAPS</td>
<td>Capital letters indicate that part of the utterance which is louder than the surrounding talk;</td>
</tr>
<tr>
<td>°</td>
<td>Degree sign indicates that part of the utterance which is softer than the surrounding talk;</td>
</tr>
<tr>
<td>*</td>
<td>Asterisk sign indicates that part of the utterance which is spoken faster than the surrounding talk;</td>
</tr>
<tr>
<td>~</td>
<td>Tilde sign indicates that part of the utterance which is spoken slower than the surrounding talk;</td>
</tr>
<tr>
<td>...</td>
<td>Indicates a pause unless precisely timed;</td>
</tr>
<tr>
<td>...&lt;#&gt;</td>
<td>Indicates a precisely timed pause; the number enclosed in brackets indicates the number of seconds;</td>
</tr>
<tr>
<td>(xxx)</td>
<td>Parentheses indicate an unclear word or a guess at an unclear word; e.g., Speaker 1: yes, she (said) it was ok;</td>
</tr>
<tr>
<td>[xxx]</td>
<td>Brackets indicate non-lexical phenomena, vocal and non-vocal, which interrupts the lexica stretch; e.g., Speaker 1: [clears throat]; e.g., Speaker 1: [giggles]; e.g., Speaker 1: hi there [speaker opens the door] come in and sit down;</td>
</tr>
<tr>
<td>[</td>
<td>Left-hand bracket indicates simultaneous utterances linked together when two speakers start talking at the same time;</td>
</tr>
<tr>
<td>]</td>
<td>Left-hand and right-hand brackets indicate overlapping utterances of two or more speakers talking at the same time;</td>
</tr>
<tr>
<td>=</td>
<td>Equal sign indicates latching when one speaker immediately follows the speaker before, without any pause.</td>
</tr>
</tbody>
</table>
This method has been further developed and illustrated as a five-part hermeneutic circle of understanding. Within this circle, the metaphoric stages of narrative interpretation are interconnected in a spiral. These stages are 1) the surface, 2) letting go, 3) delving beneath, 4) moving past the ugliness, and 5) discovering hidden beauty.

First, I started on the surface. The surface is what was plain and obvious in sight—the lexicon and syntax of the text or the words and its arrangements. I listened to each interview conversation, at a minimum, three times. This made me attentive to the way that participants spoke their words, not just what words were said. Next, I had to let go. This meant, before grouping conversational excepts into general categories, I had to intentionally put aside the texts' formal semantics or logical meaning. At this stage, I paid particular attention to the way the text was narrated, not just the words used in the narration. Unique characteristics of speech delivery (things like utterances, distinctive pronunciation, pauses, and gaps between utterances, body language, intonation accents, volume, syllable length, and tempo), were carefully transcribed according to the transcription conventions detailed in table two.

Next, I delved beneath and moved past the ugliness. Delving beneath meant I pieced together the texts’ lexical semantics or word meanings and relations. Individual interview transcripts were analyzed using a recursive open-coding method. Open-coding has been described as a process whereby researchers, code data in every possible way [which leads to] the consequence of a multitude of descriptions for possible concepts that often do not fit in the emerging theory . . . and the researcher ends up with many irrelevant descriptions for concepts that do not apply. (Glacer, 2016, p. 108)
This was a messy and painstaking process that took over 200 hours of close-reading to complete. Close-reading is a careful and deliberate process of critically analyzing text by reading it word by word, to develop a thorough and detailed understanding of the texts’ form, fashion, meaning, and emergent patterns (Klages, 2006/2011).

Next, moving past the ugliness (i.e., the chaos of close-reading codes), I organized the texts’ cognitive meaning into conceptual categories and emergent trends. This was an iterative process that involved constantly comparing and critically evaluating the suitability of codes found within individual transcripts and those shared across transcripts. Recurrent keywords and phrases, shared ideology, and distinctiveness of interview texts formed the basis for each conceptual category. For example, interview excerpts that described exhaustion due to workload stresses or demands were coded under the category of “burnout” (refer to figure 2). Later, excerpts under the category of “burn-out,” were further categorized into the sub-categories of “mental” and “physical.” Where categories overlapped or connected (e.g. “burnout”, “difficult to do job”, “ethical conflict”, “leaving the profession”, and “safety issues”), themes were created (e.g. “consequences of lack of self-care”) and categories and codes were clustered together (refer to figure 3).

Next, overarching themes were developed. Unlike grounded theory, where sub-themes are linked together (Ryan & Bernard, 2003), interpretation of this study’s results
Figure 2. NVivo screenshot illustrating interview excerpts coded under “burnout.”
Figure 3. NVivo screenshot illustrating the organization of sub-themes into over-arching themes.
were informed by a post-structural analysis of language constructs in participants’ narratives. Specific consideration was given to word relations in which one term (usually the first) preferences the other according to the social, political, and cultural power paradigms at play. This created categories of *binary opposites*, which were further interrogated and interpreted as “what is” and “what is not” nursing professionalism and self-care. A key part of this interpretative stage involved the use of photographic images, selected from open source internet websites. I’ve referred to this stage as *discovering hidden beauty*. The images themselves, provided non-hierarchal access points for me to enter the interpretive space and make meaning of participants’ storied texts—beyond what was obvious on the surface. For example, when participant Abbey likened the appearance of nursing professionalism to a 1940s picture of a happy, smiling nurse, it prompted me to search the internet for images of 1940s nursing posters. I found several images, using search phrases such as “1940’s vintage nursing poster” and “World War II nursing recruitment advertisement,” that I pieced together into a graphic collage. The collage (refer to figure 5 in chapter 4), in turn, directed my textual analysis towards the over-arching theme of nursing professionalism as “looking the part” or being the “picture-perfect nurse.” Stock, Sameshima, and Slingerland (2016) have referred to this process as *ekphrastic catechizations*, or questioning within specific themes to guide the analytical process of the data visualizations . . . [whereby] “Ekphrasis is a rhetorical device where one medium tries to re-create an object’s essence and form in another medium in the hopes of relating more directly with the audience.” (Maarhuis, Sameshima, & Chalykoff, 2014, np). To catechize is to question systematically. In this framework,
catechizations are used to direct conversations when looking at collections of artifacts in order to move the dialogue forward and to further inspire questions from investigators and audiences. (p. 495)

Although the way I have illustrated my hermeneutic circle (refer to figure 4) may appear sequential or somewhat step-wise (i.e., moving outward from the surface inwards towards hidden beauty), like Heidegger’s hermeneutic circle (cited in Mantzavinos, 2016), its foundation is ontological. The whole circle (i.e., reflection from the surface to depth) can only be understood relative to the interpretation of its parts (i.e., the individual “stages” of narrative interpretation) and vice versa. Comparably, it is important to consider the metaphor of narrative stages as being dynamic and interactive—living, breathing, and constantly evolving . . . [In some cases meaning may be conceptualized by] delve[eing] beneath the surface without ever testing the water, and likewise . . . [meaning may be understood as “hidden beauty” only] after plunge[eing] into the darkness, past the ugliness. (Docherty-Skippen & Brown, 2017, pp. 67-68)

Ethical Considerations

The research described in this dissertation was considered minimal risk, and research ethics clearance was obtained through the Research Ethics Board at Brock University before study commencement. Although there was the potential for loss of privacy (due to disclosure during the interview process), the individuals who chose to participate in this research are members of a community which affords each of its members with the collective support of the community (Noy, 2008). Noy refers to this
Figure 4. A five-part hermeneutic circle of understanding according to the metaphoric stages of narrative interpretation.
type of community membership as *social capital*, and describes these types of research participants as,

Informants who possess social capital and are willing to share it—or to perform and embody—with the researcher are those informants who are members in social networks, who have more friends and acquaintances than others (they maintain both tight and loose relationships) and are therefore located centrally. In snowball stemma, these informants are depicted as inhabiting network junctions, where their ‘network capital’ (Urry, 2003) assumes a visual manifestation. Social capital is distributed differentially within social networks, and it is this differential distribution that accounts for networks’ structure and dynamics. (p. 335)

To mitigate the potential for loss of privacy, no personal identifiers were collected. At the time of data transcription, participants’ names, persons, or places discussed during participant interviews were replaced with pseudonyms. After the interviews were transcribed, participants were sent copies of their interview transcripts. This allowed them the opportunity to add, delete, and clarify conversational details before the data being used for analysis.

**Restatement of the Study Purpose**

The purpose of this study was to explore the notion and phenomenon of self-care (i.e., the intentional way one takes care of one’s self), as a professional competency in nursing education. From a nursing faculty perspective, this study sought to address the following research questions:

1) How is self-care articulated as a professional competency in nursing?
   
a. How be this illuminated through a post-structural lens?
2) How is self-care prioritized, taught, and assessed in nursing education?

   a. Are there professional circumstances that make the need for self-care education more relevant?

   b. Is it possible to be a nurse professional without engaging in positive self-care strategies? Why or why not?
CHAPTER FOUR: FINDINGS AND DISCUSSION

The moral code for nurses needs little or no revision . . . the Nightingale standard . . . stipulates the following attributes essential to the ideal nurse: truthfulness; obedience; punctuality; observation; sobriety; honesty; quietness; devotion; tact; loyalty; sympathy; humility. (Hainsworth, 1949/1950, p. 238)

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In describing hermeneutic phenomenology as a method for researching ethics as lived experiences, Lindseth and Norberg (2004) declared that “you cannot just ask people what morals they have [because] often they will not be able to answer . . . [as people] live and act out their morals . . . without necessarily knowing them” (p. 145). As such, to investigate people’s ethical stance, they argued that it is necessary to consider beyond what is “openly there, ready to be observed” (p. 145).

To consider beyond what is “open,” after presenting (in table format) a post-structural analysis of language constructs found in participants’ narratives, in this chapter I detail my findings as layered accounts—merging quotes, narrative, and imagery with remnants and off-shoots of critical and reflective thought. In some instances, re-iterating participants’ exact spoken words (methodologically textualized in single-spaced quotation marks), uncovered the “essence” of the phenomena under investigation. In other instances, the phenomenon was only revealed after the spoken word had been textualized, reflected upon, re-textualized with images, and further interrogated. In all cases, I had to push past the order and structure of the text, let go, and allow meaning to emerge beyond what was obvious on the surface, and in plain sight. I had to let go of my preconceived notions about what professionalism and self-care is and is not so that I
could uncover and textualize the phenomena of self-care, as a lived experience, in the context of nursing professionalism and education. As such, I attempted to interpret study participants’ interview stories in a manner that, “make[s] the morals and the ethical thinking visible . . . not to describe and explain the morals as a social phenomenon, but to understand the experiences . . . expressed in the interview texts” (Lindseth & Norberg, 2004, p. 145). While doing this, I reflected upon Ricoeur’s (1975) idea that,

Understanding has less than ever to do with the author and his situation. It seeks to grasp the world-propositions opened up by the reference of the text. To understand a text is to follow its movement from sense to reference: from what it says, to what it talks about. (pp. 87-88)

Guiding my textual interpretation throughout the hermeneutic process was the notion that stories are not structured accidentally or by chance. Storyteller’s make narrative choices about what gets told when it gets told and how it gets told (Riessman, 2003). Not all details, events, characters, and scenes of a story are narrated. Beyond what is narrated, every story also includes what is nonnarrated and what is disnarrated (Vindrola-Padros & Johnson, 2014.) Where the narrated includes the “who and what is present in narratives, [the nonnarrated includes] who and what is not present within the story and [the disnarrated includes] what is alluded to in the text, yet did not actually happen” (Vindrola-Padros & Johnson, 2014, p. 1063).

Elements that may impede the narrator’s credibility or cause him/her to appear unfavourable, are often left out of stories (i.e., the nonnarrated). Likewise, details that the narrator considers nonsignificant are often excluded. These may include, “all of the daily, and often taken for granted, activities that are present in the events being narrated,
which might be implied, but are not specifically told because they would make the story
tedious or repetitive” (Price, as cited in Vindrola-Padros & Johnson, p. 1604). To
account for these nonnarrated elements, one must first ask the question, whose voice is
missing (Vindrola-Padros & Johnson). Responding to this question requires a familiar
understanding of the participants’ day-to-day work practices and schedules, as evidenced
through observation over time. Although this research plan did not include the
opportunity for me to observe study participants outside our scheduled interviews, having
worked alongside nurses and nurse educators in a university hospital setting, my personal
lived experiences have helped inform the nonnarrated events.

Other story details shared by participants, events and circumstances that did not
actually occur or were not actually experienced by the narrator (i.e., the disnarrated) but
have been described, in some cases with extraordinary detail and embodied emotions, are
just as important, if not more so, than story details that actually took place. These may
include details about what might have occurred in response to an alternate course of
action. Likewise, the disnarrated may include storied details from others’ stories, as a
way to present “a parallel and alternative reality” (Price, as cited in Vindrola-Padros &
Johnson, 2014, p. 1608). To formulate an interpretive narrative, the researcher must
consider the role and value that the disnarrated plays. One must ask,

If this event did not happen, why does the narrator mention it? Why does the
narrator need to include it in the story? If story-making is “fashioned to convince
others to see and comprehend some part of the reality in a particular way so that
what happens follows from the way things are portrayed to be” (Garro &
Mattingly, 2000, p. 261), what role in the convincing process are these hypothetical events playing? (Vindrola-Padros & Johnson, pp. 1604-1605)

To present this study’s findings in its livingness, interjected throughout this chapter, is academic discussion supported by the research literature. Pre-facing these findings, I have attempted to set the stage by illuminating the interview context for each of the study participants. Key excerpts from participants’ spoken words have been included in a way I felt best captured the overall essence of our conversations and participants’ unique personalities.

**Post-Structural Analysis of Nursing Professionalism and Self-Care**

Informing the overall interpretation of study results, a post-structural analysis of language constructs used to describe nursing professionalism and self-care was conducted. Centering this interpretation, was the power dynamics/hierarchal influences at play. These were expressed as categories of binary opposition, of “what is” and “what is not” nursing professionalism and self-care. Binary opposition is, the system of language and/or thought by which two theoretical opposites are strictly defined and set off against one another. . . . Typically, one of the two opposites assumes a role of dominance over the other, [and] the categorization of binary oppositions is “often value-laden and ethnocentric,” with an illusory order and superficial meaning. (“Binary Opposition,” April 23, 2019).

Key excerpts, language constructs of binary opposites have been organized into tables (refer to tables 3 and 4). In the left-hand columns are categories of binary opposition. These categories create social conditions (i.e., “those that are” versus “those that are not”), where the first word takes precedence or priority over the second word. In
Table 3.
Hierarchical categories of nursing self-care.

<table>
<thead>
<tr>
<th>Hierarchical Categories</th>
<th>Supporting quotes taken from participants’ interview transcripts</th>
</tr>
</thead>
</table>
| Mature nurses vs. young nurses                              | Abbey: “So when they come in as a student, like fourth year, I feel they complain and become negative to fit in.”  
Collette: “The age that I’m working with ranges from eighteen or nineteen to about twenty-five . . . it’s a very young-young group and . . . they haven’t learned the skill of being able to stop and think.”  
Laura: “Students who are coming straight from high school without the same work and family responsibilities . . . have not been taught that failure is possible and failure is ok, and you get back up on the horse and try again.”  
Shannon: “I was with a student . . . an individual that’s older and does have some nursing background and feeling like her values are being affected in the clinical placement.”  
Rose: “Young nurses getting into the field sort of jump in and then probably find themselves getting into difficulty . . . if you have more mature students . . . they may have more awareness about what to do.”  
Sandi: “I think the other difficulty is in undergrad nursing you are very young, you haven’t had a huge opportunity to . . . make connections and to see the fit of things.”  
Matt: We have seventeen and eighteen-year-olds in your first-year classes now . . . but I can really see the difference between the adult learners in the three-year program and the seventeen and eighteen-year-olds out of the four-year program and I think . . . it may be the lack of life experience that they have.” |
| Emergency response and rescue professionals vs. nurse professionals | Rose: “It’s like an EMS (emergency medical service) worker or a police officer, when they take that oath, they are committing to that work and responsibility to deliver that work and do all the things to protect it.”  
Collette: “I actually have a husband who is a volunteer firefighter, so he’s a first responder, and you know, he’s been exposed to lots of traumatic events.”  
Shannon: “Nurses need to be put on a priority . . . recognizing the type of work they do, the risks they face . . . like we’re doing it for other professionals . . . we need to be on that bandwagon as well. we face
trauma every day.”

Matt: “Firemen and PTSD (post-traumatic stress disorder) and police PTSD and there’s big pushes around those areas to make it normal . . . I don’t know if in nursing it’s normal.”

Sandi: “Paramedics and firefighters, they are so at the front line, I mean nurses are at the front line too, but even police . . . you only need to look at the veteran’s issues that are topical right now . . like with the military.”
Table 4.
Hierarchical categories of nursing professionalism.

<table>
<thead>
<tr>
<th>Hierarchical Categories</th>
<th>Supporting quotes taken from participants’ interview transcripts</th>
</tr>
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</table>
| Experienced nurses vs. inexperienced nurses | Abbey: “As you have more experience, you can start to manage all of that, like you can manage the relationships and the experience and the knowledge.”
Rose: “I have a sense that, having worked in palliative care for many years, that new nurses beginning into their careers, don’t have a lot of knowledge, expertise, experience, ability to handle situations.”
Laura: “The other piece of it is the experience part . . . when you’re brand new graduate nurse . . . everything is still very step wise . . . For someone with experience, essentially the to do list is shorter . . . The new grad needs to think within that care . . . because they have to delineate each piece . . . whereas experienced nurses . . . [are] not breaking it down to those singular action items.”
Matt: “From forty-year-olds/second careers and seventeen-year-olds/first time away . . . you get everything from completely lacking any insight to . . . being incredibly reflective and tons of insight and life experience.”
Sandi: “The ones . . . who’ve had personal experiences . . . or grave experiences . . . connect those dots a little more strongly.” |
| Physicians vs. nurses | Abbey: “I could see a physician pointing and doing [participant shakes right-hand up and down while pointing with index finger; spoken with authority/matter-of-fact tone] ‘this, and this, and this’, . . . Professionalism for them might represent more of doing . . . whereas nursing professionalism is more like being . . . [there is a difference between] how the world sees [these two professions].”
Dan: “They’re [doctors] just people too . . . there’s a barrier of professionalism.”
Sandi: “I think in a lot of ways, everybody looks to the what the physician goes through [but] . . . those nurses are the ones that are really doing the caring. Maybe they’re not allowed to make the [in air quotes] ‘big decisions’ about what is done, but they’re the ones who are really at the front lines and the ones left dealing with the family when the person dies. . . There isn’t the glory that the physician’s get, you know, there isn’t really. . . like it’s the nurses that are there round the clock.”
Shannon: “When I came to where I am now, totally different hospital environment, very much like,
Male nurses vs. female nurses

Abbey: “We have NO male nurses, it’s just male doctors . . . the majority of the people [female nurses] speak like that [negative and complaining] . . . It almost kind of looks like a bunch of girlfriends sitting around complaining about people.”

Dan: “I don’t think there are a lot of men in the [nursing] business . . . [so] the lunch club was men only . . . and we’d never talk about work . . . but if we go out for lunch as a mixed [men and women] faculty group, it’s just about work.”

Laura: “If you read task lists of old-fashioned nurses . . . essentially, that’s what your mom or your wife does for you, and I wonder how much of this [patriarchal attitude] is kind of just remnant idea of [in air quotes] ‘woman as carer.’ We have all sorts of anecdotal stories of moms not taking care of themselves because they’re taking care of everybody else, and it’s just kind of bled into the nursing culture and it disadvantages the women who are in the profession . . . It is also really hard on the men who enter the career because there’s this idea well, and we still say, we exclude them as male nurses rather than just nurses.”

Matt: “I don’t know. . . I haven’t felt like it’s [mental healthcare] been stigmatized or anything like that. maybe it’s a gender thing, I don’t know.”

Nurses who were emotionally stable and in control vs. nurses who were emotionally unstable and out of control

Abbey: “Knowing that the person who is caring for you is also so:o heartbroken and distraught and going through this with you like, [in a loud tone] I MEAN, NOT OUT OF CONTROL, LIKE CAN’T COPE CRYING but having tears and being respectful.”

Rose: “In our work, where we have to be-we have to be stable. Our work environment, our clients, the people we work with, our colleagues require us to be well-rounded and stable, not just knowledge, engaged and [spoken in q quick pace] ‘all those other things,’ but emotionally capable . . . In the profession of nursing, we have to have control, we have to understand our own ideas, our own values, our own ethical perspectives.”

Dan: “So I would never lose control, but you empathize and you listen and you support patients . . . I don’t believe you shouldn’t become emotional about your patient situation . . . but you have to understand that you have a role to play there and if you’re too emotionally engaged then you’re not functioning.”

Rose: “That is a responsibility of a nurse that is different than a different profession. You know, a secretary who works in a law office who isn’t caring or whose judgment isn’t affecting the life of
<table>
<thead>
<tr>
<th>Comparison</th>
<th>Quote</th>
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| Nurses vs. other professionals | Sandi: “It is a professional program, unlike other undergrad programs in university, it’s pretty unique in that way . . . I have a professional obligation, whereas if somebody were taking an English course or whatever, I mean it’s not going to make a difference to somebody’s potential safety.”
Matt: “I wish I taught English. I mean, English would be easy, there’s no patient safety with English.” |
| University trained nurses vs. college-trained nurses | Rose: “Understanding what self-regulation really meant, what their obligations . . . for practice was . . . you know, not-not all nurses, especially nurses that are still diploma nurses maybe that aren’t degree nurses . . . They need additional support, so we spent a lot of time teaching that or explaining that to them.”
Sandi: “It happened to be a college-trained nurse who . . . would be very much like [in a mocking tone] ‘oh you guys can think but can you do the tasks’ . . . For some of them, I think it was related to their own journey, like they wouldn’t have opportunities because they didn’t have the degree so they would kind of stay there . . . So, it was challenging. It was like, ok, do I have to feel bad because I’m in a degree program?” |
| Part-time nurses vs. full-time nurses | Abbey: “I’m a part-time staff member, and I have other things going on in my life, so my world is not centered around my career, like the full-time staff members who are so submerged in the environment and the atmosphere and have kind of adapted like a negativity and complaining almost.” |
the right-hand columns are direct quotes, taken from participants’ interview transcripts, that supports each category. It should be noted that participants did not directly label the hierarchical categories identified in the textual analysis. Instead, categories emerged, through dialogue. Categories that reflected the hierarchal influences of self-care included: 1) mature versus young nurses and 2) emergency response and rescue professionals versus nurses. Categories that reflected the hierarchal influences of professionalism included: 1) experienced versus inexperienced nurses, 2) physicians versus nurses, 3) nurses versus other professions, 4) male versus female nurses, 5) emotionally stable and in control versus emotionally unstable and out of control, 6) university-trained versus college-trained nurses, and 7) part-time versus full-time nurses. The power-dynamics my post-structural analysis revealed, those related to experience, gender, the physician-nurse relationship, and education, are well supported in the research literature. Studies have shown that experienced nurses felt that “their workload increased when new graduates actually began to practice,” (Ballem & McIntosh, 2014, p. 374) as often experienced nurses assigned the “problematic” task of mentoring new entry-level nurses without sufficient organizational support (Ferguson, 2011; Regan et al., 2017; Shelley, 2018). Other research has shown that gender invisibility, interdisciplinary barriers, and educational silos exist between understanding and agreement of professional practice language and behaviours amongst gender diverse nurses, between physicians and nurses, and baccalaureate degree and college-trained nurses (Butcher & MacKinnon, 2015; Kellet & Fitton, 2017; Liberati, Gorli, & Scaratti, 2016).
Interview Context

To illuminate findings in their livingness, key excerpts from participants’ spoken words have been re-storied textually in a way that mimics conversational style. This is intended to capture a “richer” and “fuller” understanding of the research context, the overall essence of the interview conversations, and participants’ unique personalities. As such, text may seem to “break” grammatical rules. Sentences may be fragmented. They may begin or end with prepositions. In general, however, the text should read and sound fluid, delivered in a way that invites readers to connect their own storied lives and the storied lives of familiar others to those of the participants. As such, transcribed text is re-storied with punctuation and capitalization as appropriate (i.e., capital letters for the names of people, places, the pronoun “I” and at the beginning of a sentence, and commas and periods to indicate breaks or pauses in conversations). Full words or phrases that are capitalized (e.g., WOW, THAT WAS AWESOME) are those that participants spoke loudly (i.e., in a RAISED tone), whereas words or phrases that are underscored (e.g., that was really interesting), are those that participants spoke with emphasis. The re-storying of non-verbal conversational elements (e.g., gestures, body language, pauses, tone, and pace) has been textualized in the “outer” narrative (i.e., the preamble or summary surround each conversational excerpt) that situates the relevance and positioning of participants’ spoken words. Words that participants “dragged out” (in a stretched sound) have been textualized using a colon sign; the more stretched the sound, additional colons are used (e.g., I’m s:::o sorry).

Abbey.

Abbey, a labour and delivery nurse, was relatively new to both the nursing
profession teaching role. She had a little more than five years of practice experience and had been teaching nursing for less than five years. Abbey was the first person I interviewed. We met, in person, on a Wednesday morning in a small campus classroom used for nursing seminars. Our interview began after a quick walk to the campus Tim Hortons.

“Before starting,” stated Abbey in a cheery manner, almost like an attempt to mask the somewhat tired undertone of her demeanour, “I need coffee. After working all night and rushing home to get my kids ready for school, I’m tired. It was a busy shift. We had eight babies and there were only three of us.”

Rose.

Next, I interviewed Rose. She was a seasoned nurse practitioner and educator with over 20 years of practice, teaching, and administrative experience. Her nursing background and area of expertise was palliative and community care. Our interview took place via video-conference on a Monday morning around ten o’clock. Through her body language (i.e., attentive posture and calm composure) and tone of voice (i.e., very professional and polite), I could tell that Rose had a lot of management experience.

“Prior to entering academia,” Rose stated, “I had the portfolio for a national care lead, so I have a lot of nursing education experience.”

What was interesting about my interview with Rose was not only the way she embodied professionalism through her mannerism but also the way she articulated what professionalism was. She described professionalism, what sounded like, word-for-word from the nursing professional practice standards. Then, approximately twenty minutes into our interview, when I asked how she described herself as a professional—and where self-care fit into that description, Rose let out a chuckle,

“You know, I talk a great line,” she giggled, “and certainly I advocate for self-care for my colleagues and students, but could I do a better job myself? Ya, probably, but I love to work, so to me, I find fulfillment in working.”
Dan.

After speaking with Rose, later that day, I interviewed Dan. Dan was a nurse educator with more than 20 years of practice experience as a nephrology nurse and nursing manager. He had between 10 to 20 years of experience teaching nursing. We met in the afternoon around three-thirty, in his campus office. His office was situated in an administrative corridor (somewhat off the “beaten” student path) alongside 20 other nursing faculty offices. With popular sci-fi movie posters and figurines adorning his office walls and bookshelves, the cupboard doors behind his desk were affectionately plastered with family photos. Dan started his interview by pointing to his collection of photos,

“This,” Dan stated in a proud and confident tone, “is the reason that I do the kind of work that I do and the way that I chose to live my life.”

Fifteen minutes into our conversation, Dan’s telephone rang.

“Sorry,” said Dan, “it’s important that I take this.”

After a quick conversation of muffled “hmm’s” and “ok’s,” Dan hung up the phone and explained to me that one of his students who had experienced a major mental health crisis in class the week prior and later was admitted to the psychiatric ward, was having difficulty coping. She was considering dropping out of the program.

“She’s really struggling, so I just need five minutes to chat with her. I’ll be right back.”

Twenty minutes later, Dan returned to the office, slightly out of breath.

“Sorry about that,” he said, “I just ran back from a colleague’s office where this student was. She’s in there just crying her eyes out, not wanting to go back to class. We see that so much with students. They are young and vulnerable, and the program is high-pressure.”

Our interview continued for another ten minutes, then there was a quiet tap, tap on Dan’s
office door. Dan got up from his desk, opened the door, then moved out into the hallway. I could hear Dan discussing a class assignment with some students. After a few minutes, the office door opened, and Dan reappeared.

“Sorry about that,” Dan said with a chuckle, “two of my first-year students had some questions about an assignment . . . it never ends.”

**Collette and Matt.**

The next two interviews were with Collette and Matt. Both interviews were conducted on the phone. Collette had practiced as a primary care nurse in a rural setting, and Matt had practiced as a critical care nurse in an urban setting. Both had five to 10 years of practice experience. Collette had less than five years of experience teaching nursing, and Matt had five to 10 years of teaching experience. While Collette’s interview took place on a Thursday morning around 11 o’clock, Matt’s interview took place on a Friday night (around 5 pm) after work. Collette was able to speak with me from her home, while Matt spoke to me from his car. Both Collette and Matt mentioned that they had young children and partners who understood the pressures of their job (Collette’s partner was a firefighter, and Dan’s partner was a nurse). When I asked them to share their thoughts about nursing professionalism, Collette expressed concern about perception. She said,

“The more you do, the better you are, and so the more professional you are, the more you produce, and the more you complete, the better you are.”

Chuckling, Matt agreed. He said,

“Yeah, I think there is some truth to that” Matt agreed, “I mean, look at us talking right now, what is it five o’clock and it’s Friday night? I’m sitting in the pool parking lot after dropping my kids off at their swimming lessons, and I’ve got half an hour or forty minutes or whatever an hour, so let’s cram this call in here now.”
Laura.

On Friday following, around 3 pm, I interviewed Laura, in person, at her campus office. Laura had practiced as a gerontology nurse for 10 to 20 years, and she had five to 10 years of experience teaching in a nursing program. Laura worked in an urban care setting. Her office was set apart from the other nursing faculty offices, in a separate area—highly visible and accessible to students. Before our interview began, Laura was speaking to two students in her office. Laura concluded their meeting with an animated laugh and well wishes for the weekend, then she invited me in. Instantly, I was drawn to Laura’s bubbly smile and kind personality. To describe her, the phrase “she glowed” comes to mind, almost as though she emanated radiance. Curiously enough, this notion of luminosity resonated when I asked her to describe her thoughts about nursing professionalism.

“When I think of professionalism in terms of nursing,” Laura explained, “I think it's someone maintaining calmness regardless of how phonetic everything else becomes around you—while at the same time, there needs to be this breaking of warmth.”

In the background, the recurrent dings of computer email notifications sounded in chime to the telephone rings from the nearby secretary’s office.

Shannon.

I interviewed Shannon, an emergency and critical care nurse who had worked five to 10 years in a rural area via video-conference after lunch, on a Monday afternoon. Shannon had less than five years of experience teaching nursing. With papers piled high on her desk and filing cabinets, she looked “swamped” with work. Shannon told me that she had transitioned from clinical nursing and now works exclusively at her college, teaching in all of its nursing programs. She said,
“Everything from PSW (personal support worker) to practical nursing to our bachelor of science nursing collaborative program,” she stated. “I’m not practicing at the bedside anymore I am full-time with the college.”

Shannon was very passionate about the topic of self-care, especially as it related to her interactions with students and her “negotiated” identity as a nurse and educator. With a partly-suppressed laugh, as though in disbelief, Shannon stated,

“Interestingly, we have one counsellor for a thousand students, [deep breath exhale], and she’s not full-time . . . although we have a counsellor whose quite capable and quite willing to meet with students, students tend to come me or another faculty member that they trust first. . . . Last year it was an eye-opening experience. . . . I was taking on massive student burdens, self-care, around risk behaviours, wa:ay out of my league, so it’s a kind of like, nurse [body language - hailing], but you know, I’m an educator . . . finding that fine line . . . it’s a challenge.”

Sandi.

Sandi, the last person I interviewed, was in the final stage of completing a doctoral degree in nursing. Because of her super busy schedule (teaching, finishing school, and being a mother of two young children), it took us several attempts to schedule a time to speak. Having practiced as a palliative and community care nurse for five to 10 years, Sandi had taught nursing for five to 10 years. We met in person, on a Thursday afternoon. On the main floor of the health science library of the busy teaching-hospital campus Sandi worked and studied in, we seated ourselves in a quiet study room, steps away from the hustle and bustle of the circulation desk. Immediately after we finished our introductions, Sandi perched forward in her chair. She was attentive and ready to be interviewed. Although her initial mannerism reflected the busy, fast-paced atmosphere that the campus prevailed, once we started talking, Sandi appeared more relaxed. She told me that she had taken a break from teaching this past year, which helped give her a renewed sense of focus. She explained,
“I definitely think it is important to have breaks from teaching, like I did this past year . . . it was good for me, so that next year, I’ll go in with a fresh new perspective.”

What I appreciated in Sandi, was her ability to be serious and light-hearted at the same time. After describing an incident in which she had been bullied by one of her clinical instructors, when I asked her what she would have done if she had to work for that person permanently before I could even finish my sentence, Sandi jumped in by saying, “I’d SHOOT myself!” After that, there was an awkward moment of dead silence . . . and then, . . . we laughed.

**What is Nursing Professionalism?**

After participants answered simple demographic questions related to gender, practice location (i.e., remote, urban or rural), area of expertise, years of experience as a nurse, and years of experience teaching in a nursing program (refer to table 2 in chapter 3), I asked them the question, what is nursing professionalism? Even though all participants received copies of the interview questions at least one week before their interviews, participants had difficulty answering the question, and they all required a moment to reflect before answering. This embodied reaction is reflected in the muffled "hmm’s," “um’s,” “whispers.” *(spoken words that were whispered are denoted with degree symbols preceding, and following the whispered word, e.g., °whispered°,” and silent pauses reflected as direct quotes taken from participants interview transcripts as follows:

Abbey: “That’s kind of a tough questions,” [spoken quietly, like a whisper] . . . [pause for 3 seconds], “um,” . . . [background noise - people talking - words muffled] . . . [pause for 3 seconds], “hmm,” [pause for 3 seconds, puzzled facial expression].

Rose: [Deep breath in] . . . [pause for 5 seconds], “I thought about that long and hard.”
Laura: “Um,” . . . [pause for 3 seconds], “what comes to mind when I think of nursing professionalism?” [spoken quietly, like a whisper] . . . [pause for 6 seconds], “Interesting question,” [spoken quietly, like a whisper].”

Matt: [Pause for 3 seconds], “hmm, that’s a good question.”

Shannon: “Um,” [deep breath exhale] . . . [pause for 5 seconds], “hmm.”

Sandi: “Hmm . . . [pause for 3 seconds], “nurse professional,” [spoken quietly, like a whisper].

“Looking the Part” and “Picture-Perfect”

Metaphors and images of nursing professionalism embodied the nurse as “looking the part” or being “picture-perfect.”

Abbey’s response to the question, “what is nursing professionalism,” was interesting because of the way she embodied her answer. Her voice sounded brazen and demure at the same time. Abbey was a tall, slender woman with beautiful long hair that was tied back in a pony-tail. She was gorgeous. With puzzled eyes and a half-hearted grin, she paused for several seconds, nine to be exact, before giggling and whispering,

“Hmm, that’s kind of a tough question.”

Muffled sounds from the corridor, students laughing and telephones ringing, contrasted the solemn tick, tick, tick, of the 12-inch wall clock perched just above the classroom door. Again, Abbey giggled.

“I keep seeing a picture of a happy nurse who is smiling . . . like a 1940’s picture . . . but that’s not where I want to go.”

“Hmm,” I remarked, “that’s interesting.”

Looking somewhat embarrassed, Abbey giggled some more. Perhaps she considered the image she just described as stereotypical.
“I’m really not sure why, and it really isn’t where I wanted to go. I was hoping to think of something more creative here . . . perhaps I see that image because I feel that there is this pressure for nurses to be perfect all the time, you know . . . always smiling, always being there ready help.”

In the background, the clock kept ticking—it was a little after ten o’clock on a Wednesday morning.

After our interview, I started thinking . . . what does a 1940s nurse look like? I searched the internet to find out. Using the search phrases “World War II nursing recruitment advertisement” and “vintage nursing poster,” I found several public domain images. Nurses in military uniforms—smiling, with picture-perfect hair and shiny red lipstick. I pieced nine images (labeled sequentially, e.g., Image 1, Image 2, Image 3, etc.) together into a graphic collage (refer to figure 5). These images have been cited under references, starting with image titles “WWII.” As I examined the photos and thought about their significance, the idea of a nurse professional, as “looking the part” or being “picture-perfect,” started to emerge. None of the 1940s photos I found depicted nurses as anything but “picture-perfect,” and all images, reflective of the workforce socio-demographics of the time, were gendered female.

In subsequent participant interviews, the notion of nursing professionalism as being something “picture-perfect” resonated—but only when participants were asked to compare nursing professionalism to metaphors or imagery. Rose, a seasoned practitioner and educator with over 20 years of experience, likened the image of Florence Nightingale to what she described as

“Being the person who some might say is the perfect nurse,” even though she admitted, “I’m not sure that Florence was perfect.”

Other metaphors and imagery used to depict nursing professionalism included a nurse in her uniform presenting with full name-tag and designation, a capable, empathetic nurse
who is engaged in her work and willing to help others, and a nurse who can maintain calmness and convey warmth, despite the surrounding storm. In all of these depictions, the nurse professional presents herself as happy, cooperative, kind, and self-controlled. This portrayal of nursing is consistent with the “grand narrative about nursing—still predominantly a female profession (Jones & Gates; Snyder & Green) — a story that both nurses and non-nurses tell, it is the idea of ‘the good nurse’” (McAllister & Brien, 2015, p. 79).

**Ethical Virtues of the “Good Nurse”**

When participants described nursing professionalism without using imagery, metaphors, or stories, they did so by affirming the positive values and attributes of an ideal person performing the role of a nurse professional as “good” or “virtuous.” Participants re-stated the College of Nurses of Ontario’s (CNO) and Registered
Figure 5. A digital collage of WWII nursing recruitment posters embodying the notion of the “picture-perfect nurse.” Note: References for image titles start with “WWII.”
Nurses Association of Ontario (RNAO) professional practice standards and ethics
guidelines, and words such as “trust,” “respect,” “integrity,” “ethics,” “morals,”
“responsibility,” “accountability,” and “honesty” were at the forefront. Matt said,

“I think about some good characters in a person that they would need to have in
order to be a professional nurse . . . things like respect and trust and treating
people like human beings, being honest and having certain ethics and morals and
all of that is very important to nursing professionalism.”

Dan said,

“The global image to me, of nursing, is about mutual respect.”

Shannon said,

Keywords would be accountable, value set . . . you know, finding your-passion and-and kind of caring with that on an everyday basis.”

Sandi said,

“When I think of nursing professionalism . . . I always think of integrity, and
accountability. Those sort of words are at the forefront when I think of that.”

Further qualities and attributes of a nurse professional were categorized as “being,”
“having,” and “something.”

“Being” a Nurse Professional

In this first example, participants described nursing professionalism as an inherent
yet elusive state of “being”—something for which not everyone is capable of. Leaning
back in her chair, with her eyes wide open, Abbey stated,

“It takes a certain type of person,” with a strong emphasis on the word type, “to
be a nurse.”

Laura echoed this sentiment. With a gentle soft smile, she explained,

“Some people will come into the profession just with that kind of temperament,
that you are already, somewhat wired that way . . . I think it has less to do with the
role and more to do with the individual person.”

Rose described nurses as people who have a “special-make-up” and can be “grown” or
“built” for the next generation. Specifically, she stated,

“You can’t speak about professionalism without thinking about the nurses themselves. It’s not-it’s not just a work environment, it’s not just a way of being, it is ultimately that human being that encompasses all of those traits . . . People have a special make-up for that particular type of work . . . and we’re growing them, we’re building them for the next generation of need . . . Do I think anybody can be a nurse? No. I don’t think so . . . and I think we see that in our student population. they may all want to be a nurse, but it doesn’t mean they should be or can be, effectively.”

“Being” was also used to describe the way a nurse professional is. More specifically, a nurse professional is someone “being caring.” This was described by Rose and Laura. Rose said,

“We’re a caring profession. nursing is a caring profession, it’s the foundational reason why we do the work we do. Some of us are much more caring than others, there’s no question about that, but there must be an element of it whether you are a young female or a male, or an older student, or whatever, it has to come from somewhere.”

Laura stated that

“Patient care is the absolute reason . . . for being a nurse.”

Sandi described nursing professionalism in terms of its responsibility. Specifically, she stated,

“It’s no small thing to be tasked working with someone who is in an extremely vulnerable situation . . . [nursing] is a very privileged position, but I also think it comes with a strong responsibility.”

Both Abbey and Sandi further describe a nurse professional as someone being “a people person.” Abbey stated,

“Well, nursing IS working with people, working with clients.”

Sandi stated,

“Nursing is fundamentally a very people-oriented profession, I mean there are very few people who work in the profession that aren’t connected to people in some way, so if you’re not a people person, I think it’s kind of a difficult fit in that regard.”
Other personal attributes associated with “being” a nurse professional included goodness, calmness, patience, and gentleness, evidence in the way in which one conducts or behaves him/herself. These words are reflected in Abbey’s statement as follow,

“A good nurse must know how to be calm and patient and gentle . . . like how we conduct ourselves, to me that’s the professionalism.”

In all cases of “being” a nurse professional, it involved “having” knowledge/competency and ethics/morals.

“Having” Knowledge/Competence and Ethics/Morals

In this second example, participants described nursing professionalism as something one “has,” as in “having knowledge and competence” or “having ethics and morals.” The emphasis in participants’ responses (accentuated tone) has been demarcated by underscoring those words that have been emphasized. Rose, Abbey, and Sandi describe having knowledge and competency. Rose stated,

“Right from the top, nurses need to have knowledge. They have to have proper education, they have to understand theoretical perspectives, they have to understand how practice encompasses the theoretical perspectives. They have to find their way in their own practice, they have to be able to apply knowledge, they have to be able to think on their feet, they—they have to be able to construct information as it comes to them, so critical thinking. That kind of stuff. They also have to be seekers of knowledge. They have to be looking for information . . . be open-minded, to be able to explore new ideas.”

Abbey remarked that professionalism,

“Often comes back to the knowledge.”

Sandi agreed that,

“You have to perform certain things or execute certain things or identify certain things from a scenario . . . initial competencies . . . knowledge and the ability to see a scenario, go through it . . . apply a certain set of thought criteria, and execute . . . [which entails] being at a certain basic competence.”

Collette stressed the importance of knowing your knowledge gaps as part of the ongoing
professional development. Collette stated,

“When looking at your professional development needs, [ask yourself] what is the knowledge that I have and what is the knowledge I need.”

When it came to having morals and ethics, Matt stated,

“Ethics is the first-kind of word that comes to my mind. Having good ethics, ethical character, knowing the difference between right or wrong. When someone’s safe with a decision you’ve made . . . [and] making that decision based an ethical perspective, a professional perspective.”

**Nursing Professionalism as “Something”**

In this third example, nursing professionalism was described as “something” . . . “something one loves to do” and “something mandated” by professional practice standards, guidelines, the College of Nurses of Ontario (CNO), and the Registered Nursing Association of Ontario (RNAO). When describing nursing as something one loves to do, participants’ eyes lit up. They shared those experiences in their *livingness* through expressions of embodied action and feeling. Textually, this has been demarcated in capital letters (which indicates that part of the utterance which is louder than the surrounding talk), the colon sign (which indicates a stretched sound and is placed after the stretched vowel—the more stretched the sound, additional colons are used), and underscoring the words participants emphasized.

Abbey: “This is something I lo::ve to do.”

Rose: “I love to work, so [um] to me, I find fulfillment in working [as a nurse].”

Dan: “I love this job.”

Shannon: “I FELL IN LOVE with nursing, hated high school, but fell in love with nursing and I just dove right into it.”

Matt: “So the job never ends . . . but I love it . . . I think we are afforded a privileged lifestyle too.”

Laura: “I lo:ved what I did . . . it’s a fantastic profession [huge smile].”
When participants spoke about professionalism as “something mandated,” they referred to self-regulation, as outlined by the College of Nurses of Ontario (CNO) or the Canadian Registered Nurses’ Associations (CRNA) professional practice standards and guidelines. In stark contrast to the way participants described their love for nursing in its livingness, their verbal tone, and body language was serious—reflective of their professional obligations and responsibilities to a regulatory body. Textually, this tone has been demarcated by underscoring the words participants emphasized. Rose stated,

“We are a self-regulated profession . . . the RNAO (Registered Nurses Association of Ontario) has best practice guidelines around professionalism. It also speaks to how that contributes to healthy work environments and things like that . . . When I started to write down what things were important for me, to be a professional nurse, and how nurses can demonstrate professional, it was all of those things that had been identified through the best practice guidelines.”

Collette remarked,

“The first thing that comes to my mind . . . is the public perception of nursing and I always go back to survey after survey. In Canada, nurses are always in the one, two or three, as most highly respected professions in Canada. When I think of professionalism, I really think of our standards of practices and our ethical guidelines.”

Sandi agreed,

“First of all, you’re responsible to a professional body. There is that accountability to the college of nurses . . . as an educator, you’re preparing nurses, to be accountable to that professional body.”

Although McAllister and Brien (2015) warned that by, “repeatedly constructing nurses as “good,” . . . nurses are effectively dehumanized and undermined. . . . [which] ironically traps nursing and nurses (who are still predominantly women) into a continual one-dimensional, unrealistic and de-humanised portrayal,” (p. 78), on the surface, this study’s findings supported the notion of the “good” or “virtuous nurse,” as well as its binary opposite, the “bad” or “unprofessional” nurse. A more complex representation of
nursing, however, as an “ethical paradox” between “good” versus “bad” and “immoral” versus “just” and that of a “negotiated identity” amongst the roles of caregiver, educator, advocate, parent, and partner was uncovered in participants’ disnarratives. These disnarratives (i.e., third-person storied events not actually experienced by the narrator) described nursing colleagues and nursing students who acted unprofessionally. These stories present “important counter-points to the “good nurse,” which, when examined closely, yields a more nuanced, albeit sometimes shockingly gritty, realistic reading” (p. 79).

**Stories of “Unprofessionalism”**

Stories of unprofessionalism described incidents of gender-bias bullying (i.e., female nursing colleagues bullying male and female nurses) and cheating perpetrated by nursing students. These stories opened with others positioned as lead characters while participants were witnesses to or recipients of unprofessional acts. During the telling of these stories, participants’ roles evolved into character leads as they relived experiences of “standing up to” or “rising above” others’ unprofessional behaviours. Participants embodied their stories by speaking quickly, whispering, and emphasizing words with strong, scolding tones and expressions. As a way to further emphasize the details of their stories, participants also engaged in body language and facial gestures (e.g., pointing fingers, pulling hair, using ‘air quotes,’ tossing pieces of paper on the desk, smirking, smiling, and giggling). In all cases, participants recounted how they resolved these difficult situations, by making career changes (which allowed them to “take back” their autonomy) and using those moments (exemplars of how not to behave as a nurse professional), as a way to reconsider their values, ethics, and relational ontology.
Stories of bullying.

Bullying, in a workplace context, occurs when professionalism is lacking. It creates situations that cause harm to the person(s) who are bullied. The Canadian Centre of Occupational Health and Safety (CCOHS) defines workplace bullying as, acts or verbal comments that could ‘mentally’ hurt or isolate a person in the workplace. Sometimes, bullying can involve negative physical contact, as well. Bullying usually involves repeated incidents or a pattern of behaviour that is intended to intimidate, offend, degrade or humiliate a particular person or group of people. It has also been described as the assertion of power through aggression. (CCOHS, “Bullying in the Workplace,” 2019)

All stories of bullying were gender bias. Participants described incidents in which they experienced bullying, as perpetrated by female nurse colleagues. Four of these stories were stories shared by Abbey, Laura, Dan, and Sandi.

Abbey’s story of bullying.

Abbey’s story of bullying described the negativity of some of her hospital colleagues on a day-to-day basis. Her story elucidates the metaphors of the “culture at the desk,” and a “negative downward spiral,” and something likened to “a bunch of girlfriends sitting around complaining.” Abbey prefaced her story by highlighting the power-dynamic between male physicians and female nurses. She stated,

“We have NO male nurses, it’s just male doctors . . . sometimes female nurses can be caddy and talk about you behind your back.”

Then, Abbey described a situation in which an older, more experienced nurse colleague responded harshly to one of Abbey’s usual morning greetings.

“After I said, ‘good morning to everyone,’ this one [nurse] glared at me then snapped, ‘OH, YOU HAVEN’T BEEN HERE LONG ENOUGH . . . YOU’RE
TOO NEW, YOU HAVEN’T BEEN TARNISHED YET, YOU WON’T BE WALKING IN HERE SAYING GOOD MORNING TO EVERYONE HERE FOREVER!”

When I asked Abbey how she handled that situation and whether it was stressful for her, she responded emphatically, “IT WAS.” Then she stated,

“I took a deep breath and just told her ya, I AM! and I’m going to remember you said that [giggle], and I’m going to say [in a sing-song tone] good morning to you tomorrow [giggle], and the next day, and the next!”

Laura and Dan’s stories of bullying.

Laura and Dan’s stories of bullying, like Abbey’s, took place in the hospital setting, yet they described key incidents (i.e., “near misses” or “instigating factors”) which threatened their family lives and prompted them to change their employment situations. They both spoke about leaving the hospital workplace to assume leadership roles in academia.

Like Abbey, Laura prefaced her story of bullying by highlighting the gender bias of bullying within the nursing profession. Laura stated,

“You hope your colleagues would be more empathetic, but I don’t know if it’s because we’re a female-dominated workforce, and we tend to have some [air quotes] ‘relational issues’ in terms of being nice to one another.”

Following this, Laura described a situation in which she was asked by her nursing manager, to work an extra overtime shift. When Laura attempted to explain why she was unable to work the extra shift—because she had to pick her daughter up from daycare—her manager threatened to report her to the College of Nursing for professional misconduct. In a harsh and unsympathetic tone, Laura recounted her manager’s words,

“Well, what are you going to do when the college of nursing comes calling, saying you’ve abandoned your patients?”

To this comment, Laura responded,
“Well, I’d rather deal with that phone call, than the phone call from children’s services because I’ve abandoned my daughter!”

When I asked Laura if her response was typical in terms of how most nurses would react, Laura sadly admitted “no,” and that a lot of her peers, nursing students, and entry-level nurses would have been “cowed” into working the extra shift out of fear. Specifically, Laura stated,

“I can absolutely see how somebody could be cowed into that [working the extra shift], over even just feeling that fear of [spoken at a quick pace], going to get the daughter anyway, but the rest of the night thinking [in a whispered voice], oh my gosh, am I going to get a phone call from the college? Are they reporting me? . . . or, [in an efficient but curt tone], the next day [taking a piece of paper and tossing it on her desk], their [resignation] notice is on that person’s desk.”

Dan’s story of bullying centered around his parental leave. Specifically, he spoke of being disciplined because of his gender, which prompted him to leave the bedside for a job in academia. Dan said,

“After my wife went back to work, I took four months parental leave. On my first day back, I was pulled aside and I was disciplined, for taking parental leave. They said [in a scolding tone -- body language, pointing finger] ‘male nurses don’t take parental leave here.’ My director said, ‘the vice president believes,’ now my director was female and my vice president was female too, ‘male managers don’t take parental leave.’ . . . So after that meeting I instantly started looking for a new job [chuckle], and I gave them my resignation and I walked away . . . Now this was many years ago, but there’s a real stigma, still, for men who take parental leave.”

Sandi’s story of bullying.

Sandi described an incident when she was bullied as a student, by a female nurse educator. The bullying that Sandi described was to such a degree that Sandi stated she would rather “SHOOT herself” than have to work alongside that nurse permanently. In her story, Sandi identified being “a bit older” than her classmates as a mitigating factor to the bullying. Sandi also identified the power-dynamic of physician versus nurse (Sandi
was scolded for “only speaking to the physicians”) as another mitigating factor to the bullying she experienced. Sandi said,

“I remember as a third-year student having an issue, [in a whispered voice], I was on a pediatric placement, with a tutor... she said [in a critical, mocking tone] ‘well, I don’t ever see you speaking to the others, you’re only speaking to the physicians,’ as if I was looking down [at the others]. I said, ‘well maybe because I’m a bit older [than you] and they probably think I’m the nurse,’ so there was this dynamic of being a mature student in a nursing program... At times, as a student, it was just, [body language, pulling at hair], ‘get me out of here!’”

When I asked Sandi, how she navigated those “get me out of here” moments, she responded in a matter of fact tone,

“Our just suck it up, don’t say anything, and just get through it... I just couldn’t wait to be done with her.”

**Stories of cheating.**

Cheating (which is “lacking” in professionalism) was described as something students do. In response to this, participants expressed feelings of high stress and ethical conflict. Matt and Sandi told two of the most flagrant stories about student cheating.

Matt and Sandi each had 10 to 20 years of experience teaching in a nurse education program. They both expressed serious concern about the potential for patient harm (i.e., through negligence, not knowing how to perform safe nursing care, by “bending the rules,” or not giving “good” care altogether) by “passing” students who either lacked clinical competency or “the ethics” associated with “being” a “good nurse.” Having to “deal with these issues” trapped Matt and Sandi in an ethical paradox. They described this paradox by contrasting their responsibility as nurse educators, as being greater than someone who “taught English.”

**Matt’s story of cheating and ethical conflict.**

As Matt told his story, I could hear the stress in his voice. He spoke quicker, his
tone became louder, and he placed greater emphasis on certain words. In his story, Matt didn’t feel supported by his administration. He alluded to having a “negotiated identity”—as an educator (trying to support his students, especially those who came from “pretty rough places” and were trying to “make their life better by getting a good career,”) and as a professional nurse, gatekeeper, and protector of the public. Matt said,

“We have this huge problem with cheating. People buying access to test banks, people tapping their pencils, once to mean ‘A’, twice to mean ‘B’ for the partner to know what to put down on tests . . . People who buy their papers, like I’ve put so many plagiarism things forward to the Dean . . . That it just makes me think, how can we graduate these people to be nurses when they’re doing this?”

When I asked Matt if he felt an ethical responsibility towards cheating, he adamantly responded,

“Oh totally! . . . We have students coming from pretty rough places and trying to get through the program and, do we fail them? Do we bend the rules? Do we pass them on? You kind of always get stuck in these little ethical situations where you don’t know what the right thing to do is. . . I just had a single mom who is trying to get back into school and half way through the first semester, they’re not coping but they get 59% on a test. Do I bump that up to a 60? Do I not? Those circumstances are more challenging to me now. . . . I wish sometimes I taught English [chuckle]. I mean English, would be easy. There’s no patient safety with English . . . you can do whatever you kind of like [chuckle], but when we’re teaching nursing, there’s a patient safety aspect. Then you’ve got the human side of things too and you’re trying to protect the public by not passing along people who might not be safe, but yet these people are coming from really, really tough situations and they’re trying to make their life better by getting a good career and this sort of thing. Like there’s a real tension in there. There’s no black and white.”

Sandi’s story of cheating and ethical conflict.

When Sandi shared her story, she did so with embodied facial gestures (i.e., wrinkled nose, lowered brows, narrowed eyes, and shaking her head side-to-side). In her story, like Matt, Sandi viewed herself as a protector of the public by, “owning that,” and having “a professional obligation.” Sandi said,

“I think students always see themselves a little bit like the victims . . . They just think [in a mocking tone] ‘Ya, you guys have it easy,’ but as an educator, you
own that. Like I have a professional obligation, whereas if somebody were taking, an English course, it’s not going to make a difference to somebody’s potential safety . . . And it’s so much harder to take on an issue of academic integrity, or a student that’s not making the grade and just passing them along. I’ve seen situations, and I think, how did this student get to third year? Now I realize, they were passed along, and now I get why, because it takes so much energy to take them on. . . I once called a student ‘at risk of failing,’ and the student was, [in a whispered tone], pissed, and for the rest of the term, I could feel the gaze every week of this student who hated my guts.”

Matt’s and Sandi’s stories about students cheating, unfortunately, are well supported by the research literature. Numerous studies conducted in the United States and Canada have confirmed the prevalence of students’ academic dishonesty in nursing programs, and the consequences and impact that it has on patient safety and faculty morale (Bultas, Schmuke, Davis, & Palmer, 2017; Fida, Tramontano, Paciello, Ghezzi, & Barbaranelli, 2018; Fontana, 2009; Fowler & Davis, 2013; Wideman, 2011). One study, in particular, by Fontana (2009) echoed the same issues that Dan and Sandi raised. Specifically, Fontana states,

Addressing academic dishonesty was identified as an enormous burden to nurse educators who become aware of this student behavior. The process of confronting and reporting students involved significant risk, damaged relationships, and underscored nurse educators’ responsibility as gatekeepers of the nursing profession. Navigating this process required tremendous courage. Not all of the participants were willing to go through the experience a second time; however, the majority of faculty members stated they would shoulder the burden again. All of the participants admitted to being significantly bruised by the experience. (p. 182)

In an attempt to explain the motivation behind nursing students who cheat, Fida, Tramontano, Paciello, Ghezzi, & Barbaranelli (2018) discovered that moral
disengagement not only affected cheating behaviour, but that cheating behaviour affected moral disengagement. They defined moral disengagement as “the set of cognitive mechanisms that alter or reframe misconduct, allowing people to engage in this type of behaviour without incurring negative self-reactions or self-sanctions,” (p. 726). They suggested that

recourse to wrong-doing during a period of life in which moral development is ongoing (Colby et al. 1983; Rest 1988) may facilitate individuals’ proneness to a type of reasoning that justifies rule-breaking conduct in the pursuit of their own interests. This can be potentially echoed in their future professional life. Indeed, it is likely to predict a vicious circle, in which engagement in cheating behaviour, in turn, makes the cognition, beliefs, and reasoning that sustain it more accessible.

(p. 738)

Hence, the issue surrounding academic dishonesty is complex. It may be symptomatic of students who have experienced (or who are in the process of experiencing) a professional identity crisis. As discussed earlier in chapter two, we know that the clinical training period for nursing students is an important time during their professional identity development. We also know that personal and professional stressors experienced during this training period can hurt a student’s ability to form a professional identity successfully. If tensions exist between students’ perceived expectations of their intended role to that of reality, and if they have insufficient self-care practices to mitigate these tensions, students may be more susceptible to committing acts of wrong-doing, such as cheating. Ultimately, this behaviour affects their professional self-efficacy, as well as their attitudes and behaviours towards nursing professionalism, and self-care practice.
What is Nursing Self-Care?

Similar to the way that participants responded with stories of unprofessionalism when asked what is professionalism, when asked what is self-care, participants responded with stories of what self-care is not. Typically, these stories centered on self-care crisis (i.e., mitigating factors and reflective hindsight before and after experiences of personal and professional crisis, occupational burnout, and the need for self-care), stories of caring for others, and stories of emotionally engaged self-reflection. Stories were told from first-person and third-person perspectives. Uncovering the deeper meaning behind these stories, the “disnarratives” and “nonnarratives” supported earlier notions of nursing as an “ethical paradox” and “negotiated identity.” Both these descriptors are in line with the perplexity of a nurse professional as “looking the part,” as what is on the surface, what’s obvious and plain in sight (i.e., the daily duties and dispositions of a nurse professional) is multi-layered and often hidden. In addition to sharing stories about what self-care is and is not, when prompted, participants described self-care using metaphors and imagery. In this section, self-care metaphors and imagery are first described, followed by stories of self-care crisis, caregiving, connection, and emotionally engaged self-reflection.

Metaphors and Imagery

When participants used metaphors and imagery to illustrate what self-care looked like, themes centered on “kicking off my shoes,” “meeting basic physical needs,” and “balance and “blindsight.” When asked what self-care doesn’t look like, only one participant, Collette, was able to illustrate the concept, by likening it to a “cartoon of students throwing up and fainting—just complete panic.” Collette described the look and behaviour of nursing students who weren’t engaged in self-care. Specifically, she
recalled an incident when she walked into an exam room full of first-year nursing
students. Collette said,

“If I could draw a cartoon of it, it would be students throwing up and fainting and
just complete panic . . . That’s what I could feel in the room and it just, it floored
me. So I stopped everyone, and I said, ‘You guys need to breathe,’ and I walked
them through three minutes maybe, of breathing exercises, and you could just see
them come down, and afterwards, I had a couple of students come up to me and
they said [in an astonished tone] ‘I, I can’t believe what happened. You taught
us that breathing and I’m telling you, I felt like I was high.’ [giggles] Oh my gosh, you
haven’t been breathing for so long that [giggle] that when you take three
minutes to really get oxygen into your body, you actually feel outside of normal
[giggle] . . . So they [students] are in this state of constant stress and it has become
their normal and they don’t even recognize it . . . that when they are breathing,
they feel outside of normal.”

**Kicking off my shoes!**

More nuanced than metaphors and imagery of what self-care is not, metaphors
and imagery of what self-care is (i.e., “kicking off my shoes,” “meeting basic needs,” and
“balance and blindsight,”) was more difficult for me to interpret. So, to get a sense of
what was missing, I scoured the internet for images to further advance my internal
discourse. After an unsuccessful search for pictures of a nurse not wearing shoes, I
paralleled the image (refer to figure 6) of three pairs of white nursing shoes, worn by,
what I assume to be nurses in light turquoise coloured scrubs, to Abbey’s remarks. This
photo illustrates the complex interplay of nursing professionalism and self-care as
“looking the part.”

Trying to hold back giggles, Abbey said,

“I have a funny one [giggle] . . . This is something I love to do. . . I picture myself
sitting in the break room with my shoes and my socks off . . . Letting my feet air
out [loud giggle] . . . It’s like heaven.”

The angle of the photograph only captured the image of the nurses’ front legs, from the
knee to the floor. Not being able to find a photo depicting a nurse without shoes,
perpetuates the stereotype of a nurse professional “looking the part.” Hence, Abbey’s comment illuminates the “negotiated identity” at play between nursing professionalism and self-care. A nurse is only “professional” when her/his shoes are on. Just think about this for a moment. Have you ever seen a professional nurse without shoes? When a nurse takes off her/his shoes, because her/his feet hurt, she/he transforms from a person who gives care, to one who needs care . . . a patient perhaps?

**Meeting basic physical needs.**

Maslow (2012/1943) introduced a theory to explain human behaviour for survival and growth based on a hierarchy of needs. He reasoned that a person’s motivational behaviour progresses through stages, as different needs are met. Starting with the most basic biological necessities, (such as the need for food, water, fresh air, rest, and shelter), a person’s behaviour progresses through five different phases. After one’s basic biological needs are met, one moves towards achieving safety and security needs (such as the need for job security). After this, one moves towards love and belongingness needs (such as the need to feel love and acceptance), then to esteem needs (such as the need to
Figure 6. [Untitled digital photography of nurses’ shoes]. Retrieved from:

https://shoeadviser.com/work-safety/best-shoes-for-nurses/
feel worthwhile, competent, and independent) and finally, to *self-actualization needs* (such as the need to realize one’s full potential) (Maslow, as cited in Schmutte, 2013). When people’s needs are not met, they stay fixed at that level until those levels needed are satisfied (refer to figure 7).

In this study, all participants identified “meeting basic physical needs” (such as “eating,” “exercising,” “getting enough rest,” and “going to the bathroom,”) as what self-care looked like. This suggests that basic human necessities are not being met consistently for those in the role of nurse professionals. When linking self-care to imagery, Abbey’s thoughts were,

“Just like basic things, like getting enough rest, taking a break, getting breaks, [in a whispered tone], when you [ha] can, having meals . . . and going to the bathroom.”

In fact, throughout our interview, Abbey went into great detail about “eating at the desk” and supporting her students with food and coffee. Abbey described physicians “rewarding” the nurses after particularly tiresome shifts with “pizza” and “chocolate stuffed croissants.” Abbey also recounted how she arranged pot-luck meals with her students when her teaching seminars overlapped the breakfast and dinner hours. Abbey said,

“So last year I had an eight am class,” Abbey said. “Each morning I would say, [in a sing-song voice] ‘Just tell me,’ we would go around in the circle, ‘one word that represents how you’re feeling this morning.’ And it was always, [in a monotone voice] ‘Tired, tired, tired, tired, tired. Stressed. Tired, tired, tired,’ or ‘Hungry, hungry, hungry.’ . . . So then, for the next week I said, ‘I’m going to bring in coffee so everyone just kind of bring in a treat and we’ll have breakfast together,’ . . . and like EVERYBODY brought something in . . . we even had it down to like the napkins and plates and forks and knives.”

Both Shannon and Laura were particularly animated when describing self-care as a basic need, by focusing on one’s ability to go (or more fittingly, *not go*) to the
bathroom. In describing one of her self-care canons, with a half-hearted chuckle, Shannon explained,

“I tell myself and my students all the time that they have to, and it sounds silly, but you have to give yourself, every day, like, fifteen minutes to poop.”

With a Cheshire-like grin and a bubbly giggle, Laura said,

“When I think of a lack of self-care, I think of incontinence, and I’ve actually said this to my student, ‘Most nurses will become incontinent by the time they’re elderly, because we don’t use our bladders properly.’ . . . Some days I’ll get home and will say to my husband, ‘I didn’t go to the washroom yet today,’ . . . and whether it’s an eight or a twelve-hour shift, this is the first time I’ve gone.”

Participants’ illustration of self-care as “meeting basic physical needs,” fascinated me, as it seemed to contradict Maslow’s theory. Nurses who were described as not taking good physical care of themselves (i.e., being a “little overweight,” “not exercising,” “not eating healthy,” and “not going to the bathroom,”) also described deep moments of personal and purposeful self-reflection where they were able to make a sense of connection, experience acceptance, purpose, and meaning. This emotionally engaged self-reflection enabled participants to enter a protective domain (further discussed under the section of “Stories of emotionally engaged self-reflection and the chronotope of self-care”). In contrast, nurses who were described as having their basic physical needs met (i.e., nurses who “ate healthy” and “exercised”) or who “looked the part” (i.e., “appeared to be taking good care of themselves”) were not necessarily more advantaged to enter this protective domain. In line with this thought, Rose described an incident that took place early during her nursing career, in which one of her nursing colleagues, a person who Rose “admired” for having “everything together” and always “dressing nicely,” committed suicide. Deeply reflecting on that incident, Rose’s voice suddenly became quiet and serious. She said,
“I used to work on a mental health unit . . . and I lost a colleague to suicide who was working at the unit at the time . . . That was a **HUGE** eye-opener for me . . . This colleague of mine, she was a bit of a mentor for me. I was a new nurse, it was one of my first jobs, and I admired her. I thought she had everything together. She was always dressed nicely [smile]. She used to wear different coloured glasses on different days of the week [smile, body action holding pretend glasses up to her eyes], she was always well kept. Then, one day I came in [to work] to learn that she had committed suicide . . . Maybe there were things that I wasn’t aware of but **NOTHING** I saw at the time. For me it was a shocker . . . you know if you see someone who’s having difficulty or reacting inappropriately . . . You try to help them . . . but in her case, I did not see that and so for me, I really had to become aware . . . I had to look internally to say, what kinds of things bother me? And, I ended up leaving that particular kind of work after about eighteen months because the line between what I thought was [air quotes] ‘normal’ and what was ‘abnormal’ was blurred.”

In this story, Rose alluded to the mismatch of values she felt after her colleague’s suicide and working in that unit (i.e., the “blurred line” between what she “thought was normal and what was abnormal”). In addition to supporting the notion of values mismatch, this story also supports the notion of “blindsight” (as discussed further in this chapter). In chapter two, mitigating factors of professional identity crisis (i.e., “values mismatch”) was discussed, and how those factors influence nursing students and entry-level nurses to leave the profession altogether. In concluding her story, Rose indicated how she re-prioritized her values by “looking internally” and “leaving that particular kind of work.”

In a similar attempt to explain this irrationally (i.e., why nurses who appear to take good physical care of themselves still breakdown emotionally), Abbey ended up reconciling that she doesn’t “know how or where,” but “they’ve **LOST** it” [their purpose or vocational calling]. Abbey stated,

“They’ve **LOST** it . . . I don’t know how or where they’ve lost it . . . but I see that they are physically taking care of themselves . . . They talk about exercising and I see that they eat healthy [breath inhale] but, often I’m seeing that they leave **crying** because they are having a hard time coping.”
Further, Abbey commented that some of these nurses [those who lost their purpose or vocational calling] get trapped in “negative downward spiral of complaining” which ultimately takes away from their ability to connect to their patients and provide “good” nursing care. In her story, Abbey clearly distinguished her behaviours and the behaviours of her colleagues, by “personally removing herself from the situation.” Abbey said,

“The complaining, and the negativity it’s just not good energy that I feel, so I personally remove myself from the situation. I sit at a different desk. I don’t participate in it . . . but I think, sometimes . . that [negativity] does pour over [into patient care] . . . especially if they [the nurses who complain and are negative] don’t have a connection with their patient or they aren’t actively working on having a connection and being empathetic.”

**Balance and blindsight.**

Stories about balance, being able to find it or have it, as a protective strategy against stress and burnout resonated throughout study participants’ interviews when I asked them to illustrate self-care using metaphors or imagery. Dan said,

“For me it’s balance . . . balance is crucial.”

This sentiment was echoed by Rose and Matt. Matt said,

“I think the word balance kind of comes to mind, I mean [breath exhale], having balance in your life and being able to have other outlets in your life where you can take care of yourself whether it be mentally or physically or socially, or whatever the case may be.”

Rose said,

“The word for me would be, you know what comes to my mind is about having balance, balance in our professional lives but also in our personal lives that help our professional lives.”

What was interesting about the concept of “balance,” is that participants described it as a profound connection of the senses (i.e., synesthesia) in addition to “being” something concrete (in that it is something to “have” or “find”). Synesthesia is both a medical condition (ironically) and a literary device. In medicine, synesthesia is a *disorder* in
which one sense stimulates another sense simultaneously. For example, a person who has synesthesia may hear sounds that are perceived as light. In literary terms, synesthesia is a technique that authors use to present “ideas, characters, or places in such a manner that they appeal to more than one sense at a given time,” (“Synesthesia,” 2019). The irony that balance was described as something physical and non-physical, prompted me to further interrogate this concept with the notion that balance is also about being in an “ethical paradox” and having a “negotiated identity.” The idea that something can be hidden in plain sight, attributable to its duality, prompted me to consider the paradox of blindness and sightedness. From the internet, I selected a photograph that illustrates the duality of “blindsight” (refer to figure 8). It is a digital photo of a human eye. The photo is backlight in blue light so that the pupil appears white. Radiating from the pupil, through the iris to the cornea, are white rays of light. To me, this photo illustrates the duality of “blindsight,” where something can be hidden in plain sight.

Blindsight is a medical condition (another irony) in which “people who are cortically blind due to lesions in their striate cortex, [are able] to respond to visual stimuli that they do not consciously see” (“Blindsight,” 2019). An interesting quality of blindsight is that it contradicts the familiar notion that consciousness is a requisite for perception (in this case, visual perception). People who have blindsight can respond to sensory information, of which they have no cognizant awareness. Where, “blindsight patients show awareness of single visual features, such as edges and motion but cannot gain a holistic visual percept . . . [in] sighted individuals—there is a blinding process that unifies all information into a whole percept” (“Blindsight,” 2019). This perception process is interrupted in persons who are blindsighted.
Figure 8. Baitg, C. (photographer). (n.d.). “Blindsight.” Retrieved from:
With “blindsight” in mind, I went back through participants narratives to find examples of incidents that reflected this dualism—where participants were “blinded” to the negotiated role they were performing at the time and were only able to recognize or see the ethical paradox they were in, after they “balanced” or re-adjusted their self-care strategies. The best example I found was a story shared by Shannon. Shannon described how she had to “find that fine line” of balance after “plummeting” in response to “taking on massive student burdens” in the dual role of “nurse” and “educator.” Shannon described her experience as being “eye-opening.” She said,

“It’s finding that right balance you know, and I feel like I have a due diligence in being a nurse and protecting the community . . . I need to know that my students are safe mentally, physically, psychologically, so that they can go to clinical placement and provide safe care. I feel like that’s my duty, so I need to ensure that they’re coping and that they are working through some of these self-care concepts . . . What I find though is that students go to those who their comfortable with. So although we have a counsellor whose quite capable and quite willing to meet with students, their first step is going to be me or another faculty member that they trust. And, I have to say, last year was an eye-opening experience, because of those [personal self-care] boundaries and not respecting that, I plummeted because I was taking on like massive student burdens, self-care around risk behaviours, like [partly suppressed laugh - as though in disbelief], waay out of my league. So it’s a kind of like, nurse [body language - hailing], but you know, I’m an educator [partly suppressed laugh - as though in disbelief] and finding that fine line.”

**Stories of Self-Care Crisis**

Stories of self-care crisis, (a term I elected to describe these stories, not necessarily a term used by participants), expressed mitigating factors and reflective hindsight before and after personal and professional experiences of crisis, occupational burnout, and the need for self-care. The actual events that caused participants to experience self-care crisis were described as stories of “unprofessionalism,” in particular, “stories of bullying,” as recounted earlier in this chapter. In stories of self-care crisis, although participants articulated difficult situations that caused them to experience
emotional hardship and in some cases, professional set-back, they did not necessarily consider these stories to be “bad.” In fact, some participants resolved the anguish those experiences brought them, as the impetus for “character-building” and an opportunity for them to “reflect and readjust their values and priorities.” Rose explained,

“It isn’t until you start to experience some hardship or difficulty or some other things that begin to build your character and makes you develop into the person you’re going to be.”

These same sentiments were echoed in Sandi’s story. She reasoned that “experience” and “suffering” had a lot to with a person’s ability to enact self-care strategies. Sandi said,

“I think experience probably has a lot to do with it [self-care]. I think sometimes having, life happens a little bit, you know, things beyond your control, can help develop it . . . I mean self-care often arises out of pain, or struggle, or difficulty, or challenge. Often I think people that sail through [life] without a care can sometimes be lacking self-care. Self-care is also about empathy, and, I don’t know . . . maybe that’s because I’ve had a lot of suffering in my life [giggle]. I think it’s probably hard to be proactive before you’ve had suffering, because when things are great and things are coming along easily, it’s difficult maybe or it might even feel silly about the notion of self-care.”

Of all the self-care crisis stories participants shared, Shannon’s story struck me as being the most emotional. Right from the onset of her story, Shannon attributed the fact that she “wasn’t giving herself opportunities to properly reflect,” as a mitigating factor to her “mental breakdown.” She said,

“I’d be pulling twelve, sixteen-hour days, I wasn’t giving myself opportunities to properly reflect or to provide self-care for myself, because at the time, my work was everything. But [um] then I burnt-out, [um], and I did have a psychological crisis, mental breakdown, whatever you want to call it, where I did have to forcibly ask for help. That was probably one of the hardest things I’ve ever done . . . I don’t like to think of myself as old, but I felt old and decrepit, and I can’t even say it’s the physical aspect of the job, I mean definitely it was demanding, but it was much more mental [um] lack of support, self-esteem, dealing with trauma, like all of those aspects, you know, personal crap . . . It was much more a psychological focus that led to all my physical problems, but ya . . . it’s given me time to know that boundaries are really important.”
Stories of Caring for Others and Making a Connection

Stories about caring for patients centered on participants’ abilities to make emotional connections not only with their patients but also with themselves and their vocational calling. Participants described “these connections,” as “actually being a form of self-care.” During the telling of these care and connection stories, participants’ emotions were raw and unfiltered. They spoke slowly or quickly, and they placed heavy vocal emphasis on keywords (demarcated in capital letters, underscored, or both). Sometimes participants stuttered, repeated words, or had to pause and b-r-e-a-t-h-e.

When re-telling a time in which she delivered a stillborn baby, Abbey spoke very tenderly about “feeling the emotions with her patients” and “crying with them.” At the end of her story, Abbey spoke about being “privileged to be able to be in those moments” with her patients. In a passionate but gentle voice, Abbey said,

“If I deliver a baby that has, like a dead baby . . . a stillborn baby, I feel the emotions with my patients . . . I’ll cry with them and go through it, like I’m not [air quotes] ‘acting tough’ or ‘bottling it up,’ . . . I FEEL IT, and they [the patients] actually appreciate it because IT IS SAD for everybody . . . and from what patients have said to me, they feel more cared for, cause to them it’s [losing a child] the worse thing in the entire world. So knowing that the person who is caring for you is also so heartbroken and distraught and going through this with you like, they feel supported too. I mean, [spoken in a loud tone] ‘not out of control, like can’t cope crying,’ but having tears and being respectful, they appreciate it . . . I even had one [a stillborn] who was 28 weeks and it was just myself in the situation and we [the parents and I] were going through this journey together. The next day, they [the parents] had flowers delivered to me with a note, like the day after they had their baby . . . so that really had an impact on me [deep breath inhale and exhale] . . . sometimes I have to remind myself, like, OK [breath deep inhale] just breathe for a second, like this is this person’s LIFE here, this is THEIR situation and their journey as well, so I’m-I’m privileged to be able to be to be in this moment with them.”

Similar to Abbey, Laura shared a story about caring for one of her patients who died, “a sweet little old lady” whom she “lo::ved.” Laura described how even in those
moments of grief, she was able to find “beauty” and “honour,” which she interpreted as a form of reflective and protective self-care. Laura said,

“So in gerontology, most of my patients would end up dying . . . I-I can think of one patient, and I lo::ved her. I actually thought she had no family. I cared for her for two or three years and [she died] . . . and again, I had a fantastic team and we were very supportive of one another. But I think if you aren’t able to find value and beauty in-in that moment, and I think that is actually a form of self-care . . . It’s that reflective piece, [in a tone of wonder and respect], ‘wow, I got to be the last person that person saw, and what an honour.’ I think those pieces of reflection are a sense of taking care of myself and what that whole event meant to me emotionally.”

As I listened to study participants articulate these particular types of stories (stories of caring for and connecting with others), in their livingness, I was overcome with feelings of compassion, admiration, and fascination. It was as though I was reliving those tender moments with them—in those same times, and in those same places. I became intimately aware of how connected we had become, not just as researcher and participants, but as one human being with another. In those moments and spaces of livingness, it was as if time s- t-o-p-p-e-d. I had become completely disembodied—no longer able to feel my bruised and bleeding body—I was fully immersed in story. And, after listening to these stories, I began to engage in my own self-reflection, and what it meant to be situated in livingness. To do this, I had to s-t-o-p . . . and reflect. This prompted me to consider the idea that self-reflection (like peering into a mirror and describing what one sees), is very much trapped in time. Just like a literary chronotope is bound by the inseparability of space and time, self-reflection is situated and protected in moments of livingness. From the internet, I selected a photograph that illustrates the inseparability of time (as moments) trapped in spaces of livingness (refer to figure 9). I have titled this photo “Clock eye.” It is a digital photo of a human eye. Superimposed over the iris and pupil is the image of an analog clock (hour hand at 12, minute hand at
two. The iris and pupil are shaded in blue, brown, green, and orange. The eyelashes, cornea, and surrounding eye socket are coloured in black, white, and grey tones. Radiating from the iris to the outer cornea, are light rays that resemble electric currents. To me, this photo illustrates emotionally engaged self-reflection, where seeing is trapped in moments of time and spaces of livingness.

With the notion of the clock-eye in mind, I continued to think about what it means to engage in reflection. I thought about the paradox of embodiment and the material restriction it imposes, as a physical barrier, precluding one from entering into spaces for self-reflection. A term not used by my participants, I refer to these protective spaces or domains as “God’s space,” not necessarily because they are Godly spaces, but because in them, one experiences a transformed state of consciousness that invites emotional connection to something or someone greater than one’s self. It was in these moments, when time and space dissolved, that participants resolved the professional/self-care split by focusing their own time and space with others in life/death transitions. In God’s space, time and space are relational. Evidence of these protective domains were uncovered in participants’ stories about “taking time” and “stepping away” as chronotopes of self-care.

**Emotional Engagement, Self-Reflection, and the Chronotope of Self-Care**

According to Bakhtin, the chronotope is a distinct literary device that expresses time and space as an inseparable entity. Quite literally, chronotope means “time-space.” It is a unit of analysis for studying text according to the ration and nature of the temporal and spatial categories represented. The distinctiveness of this concept, as opposed to most others, uses of time and space in literary analysis lies in the fact
that neither category is privilege; they are utterly interdependent. The chronotope is an optic for reading texts as x-rays of the forces at work in the culture system from which they spring. (Bakhtin, 1981, pp. 425-426)

Owing to the synchronous and diachronous interplay that language and cognition claims in our understanding of lived experiences, phenomenologically, the chronotope makes possible textual inquiry beyond the boundaries of traditional linear narrative. This is useful when examining not only “the temporal complexities of the narrative structure, but also the unfinalizability, the meaning of the embodied dimension of lived experience” (Torn, 2011, p. 130). For instance, in

*Metaphors We Live By* (1980), George Lakoff and Mark Johnson argued that such language [figurative language], and metaphor, in particular, was not simply a phenomenon to be studied in the domain of cognition, but actively structures much of cognition traditionally thought to be isolated from metaphor . . . [this suggests that] many central cognitive processes, such as those concerning space and time. . . are shaped by the kinds of bodies we have that mediate between agent and world (“Embodied Cognition,” 2015)

How we come to understand things, therefore, may be embodied differently from what traditional cognitive science dictates. In fact,

Spatial concepts, such as “front,” “back,” “up,” and “down,” provide . . . the clearest examples in which such embodied experience exists. These concepts are articulated in terms of our body’s position in, and movement through, space . . . [we] think of things that are “in front of” [ourselves] . . . in the line of vision or in terms of the direction [we] . . . are moving in . . . the experience of “upness,”
proponents of embodied cognition claim, depends on the particular kind of body we have, and how that body interacts with its surroundings (Lakoff & Johnson 1999). (“Embodied Cognition,” 2015)

Embodying knowledge, in a place and space where “time, as it were, thickens, takes on flesh, becomes artistically visible” (Bakhtin, as cited in Good, 2006, p. 22) is described in participants stories about “stepping away” and “taking time.” In these stories, participants framed their experiences of livingness in directional relation and metaphorical space to encounters of “stepping away” and “taking time.” In other words, participants did not physically “step” anywhere, nor were they able to “take” or “create” time in their already tasked, eight to twelve-hour work shifts. Instead, participants became “enfleshed by the same spatio-temporal dimensions that generate and shape its space . . . by entering into the stream of consciousness that is already flowing with meaning” (Good, 2006, p. 23). Rather than telling stories according to the temporal conventions of chronological time (i.e., past, present, and future structures of “authoritative” time) participants’ stories as chronotopes invited the possibility of infinite time or time stopped, in a space and place for inward reflection. Juxtaposing this concept with the photographic image of the “clock eye” (refer to figure 9), I considered its paradoxical dissimilarly to that of the photographic image of “blindsight” (refer to figure 8). Different from “blindsight,” (i.e., seeing beyond consciousness without percept), the “clock eye” sees what is unconscious through emotionally engaged self-reflection where time stops. In this state, the body is able to dissociate from its neurological state and thereby experiences an altered state of connected consciousness (i.e., “stepping into
someone else’s space”), which is protective, regenerative, and humanizing. Specifically, Collette described this “time-space” of God’s space as:

“A luxury . . . having that space, whether time-space, physical space, or mental space, to stop and think and reflect, IS a luxury that nurses often don’t have space for.”

When I asked Collette to further expand upon this notion, she did so by providing detail about “stepping into someone else’s word” as a form of “self-care” . . . something “refreshing” and “therapeutic.” In a quiet, purposeful and reflective tone, Collette explained that:

“I’m not sure if in nursing, we’re stepping into someone else’s world for a brief moment, we’re stepping into someone’s space, and those spaces can hold a lot of weight . . . you know, I had an interesting discussion recently, because I’ve been away from my own clinical practice for close to two months now, and what I under-estimated, or what I didn’t really recognize was the value of stepping into someone else’s world for a brief moment and what that meant for my own self-care. And that at times, you would think it would make it more difficult because that would carry its own weight, but what it did was it actually allowed me space to step outside the business and rush of my own world, to truly step outside of it for a moment, which was really refreshing . . . I didn’t realize how therapeutic those days were for me, being able to just reposition my perspective and reposition what’s important to me and I did that by just taking moments to step out and maybe that goes back to having that time and that reflection.”

Similar to Collette, through metaphor, Abbey described God’s space as a protective space where she could “take time” to re-energize by “removing” herself from the “situation.” Abbey said:

“Even taking [breath inhale] five to ten minutes [deep breath – exhale] . . . to just breath . . . and remove yourself from the situation . . . it’s like heaven. . . to be able to relax and breath for a second and just remove yourself from the stress is quite refreshing [giggle] . . . But if you do:n’t have that time to yourself to get through the twelve hours, it’s harder to be the happy smiling nurse . . . just in terms of energy, like having that energy and that piece of yourself to give to those people when YOU aren’t full, you’re just breaking off more and more pieces.”

This concept of gaining “renewed energy” or “being recharged” after spending time in God’s space, echoed in Shannon’s story. Shannon likened this experience to a “form of
meditation” or “this connection” or “letting go.” Specifically, she said

“It’s being kind to yourself, allowing yourself a moment to connect with who you are . . . it’s a way to recharge . . . it’s almost like a form of meditation or-or it’s this . . connection, that I’m allowing myself to . . let things go that I don’t have control over, or reflect on things . . . it’s through reflection . . . that’s what’s helped me in the past . . it’s being kind to yourself, being able to forgive yourself.”

Taking time to “pause,” “reflect,” and “step back,” was described as a healing self-care strategy to the situation of “limping along” or “struggling.” Rose said

“Taking time in your day, to pause and reflect . . . to decompress or de-stress . . . if you’re limping along or struggling, or whatever, sometimes you need to take a step back, and fix what you can before you’re able to offer that kind of help to others.”

Although we live through our bodies and our “shared condition of being bodies becomes a basis of empathic relations among living beings” (Frank, 1995, p. 35), some academics argue that by focusing on one’s embodiment, one’s ability to dissociate their body from their neurological state (thereby experiencing an altered state of consciousness—which in and of itself may be protective, regenerative, and humanizing) may be dissuaded (Ataria & Neria, 2013; Jordan, 2012; Rapport, 2008; Spry, 2011; Vanier, 1988). In a study that examined the “architecture of human thought in subjects lacking a sense of body [i.e., they were “disembodied”] as a result of confinement and isolation,” after interviewing Israeli former prisoners of war who had endured extreme trauma due to torture and isolation, Ataria and Neria (2013) found that “threats to a normal sense of body often lead to a loss of the sense of time as an objective dimension” (p. 159). They explained that

by losing the sense of body reveals the primary structure of human thought . . . in the loss of one’s sense of objectivity because the body is not only an object of consciousness but also its rational basis. This loss of objectivity is expressed in
the collapse of one’s sense of time as an objective dimension. The arrow of time, a primary condition for rational and logical thought, ceases to exist/function. Similarly, the sense of nowness and the sense of duration collapse. The arrow of time, the sense of nowness, and the sense of duration are all created by the subject under the threshold of consciousness. In other words, time as a Newtonian/objective dimension is merely an illusion. (p. 175)

Knowing that time stands still when the body’s sense of self dissipates, it was interesting that these sentiments echoed in participants’ stories of deeply caring for others. Abbey and Laura both described “moments” of heightened emotional connection with patients during times of tragedy and death. Abbey described being “heart-broken” and “FEELING” (heavy emphasis on the word feeling) the sadness and grief of delivering a stillborn baby and how she was “privileged to be in this moment with them,” (the grieving parents). Laura spoke about the way she loved (the word loved was emphasized and “d-r-a-w-n o-u-t”) one of her elderly patients who died and how she was able to “find value and beauty in that moment.” It was almost as if “being” in those moments of deep personal connection, “like a form of medication,” enabled participants to lose sense of themselves and enter a “place” (i.e., God’s space) where they could focus, reflect, and make sense of what, in Laura’s words, “that whole event meant to me [or them] emotionally.” What further fascinated me, was that the “gateway” to God’s space seemed to be heavily laden with emotion. Sometimes its path included, as described by Rose and Sandi, “hardship,” “difficulty,” and “suffering.”

Nonetheless, “stepping into those spaces” was “powerful,” “transformative”, and, as described by Collette, “can [could] hold a lot of weight.” Hence, I pause to consider . .
is it possible for people to enter “those protective spaces” willingly? Are there individual characteristics (e.g. a person must have heightened awareness) or situational conditions (e.g. circumstances that cause a person to feel emotions of pain, love, sadness, or joy, such as the birth of a baby or the death of a loved one) that necessitate entry? And if “those spaces” truly are, as described by study participants, “transformative,” refreshing,” “energizing,” “relaxing,” or “de-stressing,” should the goal of self-care education be to enable learners to enter and navigate “those spaces” through lived experiences opposed to being provided with factual knowledge about self-care? If so, then how do we teach learners to do this, and how can we assess their ability to effectively do so? Although the remainder of this chapter discusses participants’ views about teaching self-care and professionalism in nursing education, in the final chapter, under the section headings “the power and pedagogy of reflective practice” and “the power and pedagogy of care,” I have further considered these questions as the goal of self-care education and pedagogical strategies to support learners in self-care practice.

Teaching and Assessment

Participants were asked how professionalism and self-care were taught and assessed in nursing education. In all cases, participants agreed that it was easier to teach and assess professionalism than it was to teach and assess self-care. These findings are consistent with study results that examined the teaching and assessment strategies used in Ontario nursing education programs (Docherty-Skippen, Hansen, & Engel, 2019).

Teaching and Assessing Professionalism in Nursing Education

All participants stated that the best way to teach professionalism is by modeling the “right” behaviours. This was followed by relying on the College of Nurses of
Ontario’s (CNO) or Canadian Nursing Association’s (CNA) ethical frameworks/guidance documents, posing critical questions, and engaging in ethical discussion. When discussing the importance of modeling the “right” behaviours, Rose spoke about “practicing what we preach,” and Shannon spoke about the importance of embodying what professionalism “looked like.”

When I asked participants how professionalism was assessed, Matt indicated he “used a lot of their [the Canadian Nurses Association] cases,” and that he “relied on the college’s practice standards around ethics.” Dan said he liked to pose critical questions and engage students in discussions to help them become “better” nurses. Specifically, Dan said,

“I give them poignant questions to get them thinking about their own values . . . So it’s looking at your own values . . . It’s good to talk about this, and let’s get this out in the open, let’s get those hang-ups dealt with so you can be a better nurse.”

**Teaching and Assessing Self-Care in Nursing Education**

Different from professionalism, in that it is a subject that can be taught, self-care was described as “something that is learned but not taught.” This reinforces the elusive temperament and character traits afforded to those who are “good” nurses. Rose’s comment, that “not all people have a special make-up” to be a nurse, supports this notion. Although all participants indicated that they attempted to teach self-care in their nursing programs by modeling the “right” behaviours, sharing stories, engaging in open dialogue, and creating a sense of community/connection, they weren’t necessarily confident that students could enact the self-care behaviours (when needed) they were taught. Most ambivalent about this issue was Matt. He said,

“I don’t know if nursing school teaches them that . . . I don’t know when they’re done whether they have improved through nursing school . . . Sometimes people
just don’t-aren’t able to do that, and that’s not the book learning, right? Like you can’t-it’s hard sometimes to teach people that, and I don’t know if they do learn, I don’t know.”

Although all participants cited the value of reflection, as a critical component for their own self-care, when asked how self-care education was assessed in their nursing programs, they all indicated that assessment was difficult. Typically, assessment was done through self-reflective journaling however, participants reported significant problems with this strategy. Both Sandi and Matt indicated how students don’t “buy-in” to the reflective journal process, thinking they’ve “reflected to death” or that what they do actually write is “superficial—not very deep.” Sandi said,

“Undergraduate students in the program feel that maybe they have reflected to death . . . they don’t have the maturity to really appreciate what the reflection is, so they see it as this other thing and I think they maybe can’t appreciate the value of it, so they just see it as another flimsy task.”

Matt said,

“When you’re marking reflective journaling or stuff like that, maybe I’m jaded, but I don’t think that the reflective journaling and those sorts of activities, the students probably don’t buy-in to that as much as we think they do or think they should . . . I was just marking a fourth-year thing a few days ago . . . something to do with reflection, and it just seems superficial, like it does not seem, it doesn’t seem very deep at all.”

Collette said,

“Often our reflections are now driven, when I first graduated, there was a stronger personal component to our reflections and I think we’ve moved away from that in nursing in that reflective practice is looking at your professional development needs, so what is the knowledge that I have and what is the knowledge I need, as opposed to pulling it-into the-the nurse as being one whole human . . So students are coming in, and so the idea of stopping, your study routine to take ten minutes to take care of yourself, it’s perceived as a waste of time. It’s not perceived as something that would benefit them.”
Although Rose, the participant with the most practice and teaching experience, agreed with other participants that assessment of self-care is difficult, her strategy was quite frank. She based it on performance in the field. Rose said,

“Assessment is hard but assessment is seen in performance. You assess somebody in their performance. As a manager of nurses for many years, that’s where the assessment was. The ability to cope versus the not cope, you know, if they needed help or other things.”

When participants were asked how they were taught self-care in their nursing education, all stated they learned it “on their own” as it wasn’t something “formally” taught or they didn’t remember it being taught. When Abbey, a nurse who has been practicing between five and ten years, was asked how she was taught self-care as part of her nursing education program, after a five-minute pause, cautiously, she replied,

“Hmm [pause for three seconds], I don’t think so [pause for three seconds]. I don’t know, and I don’t remember if we were taught anything about reflecting on like our own mental health or our own self-care. I don’t remember any of that. It was more like, [in a sing-song voice] ‘this is a normal blood pressure’ and like ‘these are normal vital signs’ not like, [in a sympathetic tone] ‘when you feel burnt out like, reach out to this person and or say something,’ [pause for three seconds]. I don’t remember any of that.”

When asked how she was taught self-care, Shannon was conflicted about whether it was something “taught” or something “innate.” Shannon linked self-care to professionalism, by stating,

“It’s something that I carry with me at all times not matter where I am or who I’m with. It’s a part of who you are. What I’ve been learning through, it’s not something that’s taught . . . [but] it’s not something that’s innate.”

Rose, Collette, and Laura, all indicated that even though self-care wasn’t explicitly taught in their nursing education programs, they learned it through experience. Although Collette stated that she currently engaged in reflective practice as a form of self-care, she admitted, “i don’t know, if I alwa:ys did.” Laura responded similarly. She said,
“It’s not so much taught, it’s the idea of, I’ve just got more experience, so it’s not easily taught, and certainly I think in most cases it’s not taught before graduation because you have to be more living the role to develop that expertise.”

Later in our interview, Laura talked about reflective practice. When I asked if she was taught reflective practice as a strategy for self-care, Laura responded,

“It wasn’t conscience . . . I can’t think that I was every explicitly taught that . . . you just do it.”

**Being a Nurse Professional and Not Having “Good” Self-Care Strategies**

When participants were asked if it is possible to be a nurse professional without having “good” or positive self-care strategies, after consideration and further “defining” the relationship between professionalism and self-care, in that “self-care lives within professionalism,” all participants remarked that it is not possible to sustain being a nurse professional without engaging in “good” self-care practice.

Although some participants initially said, “yes,” that it was possible to be a professional nurse without having positive self-care strategies, they were clear to define professionalism in terms of “only about work,” or as “looking the part,” as in the examples of “being an actress,” “hiding,” or “playing people.” Dan described the irony of being “those type of nurses” as ones who,

“Make they’re only focus on work . . . [and that] if you leave behind all the other stuff, then you’re not a human . . . [and] ya, people will view you as super professional, dedicated . . . but you need to walk away from work to have good health . . . right?”

In answering this question, Laura and Shannon reflected on their past behaviours, times when they didn’t take good care of themselves, yet still thought of themselves as being “good nurses.” Both Laura and Shannon qualified their answer by indicating that professionalism is something that can’t be sustained without self-care. Laura said,

“I think I’ve been a good nurse [huge smile] and I know I’ve had very bad self-
care strategies [giggle] . . . One thing I will say though, is I’m not sure it can be sustained.”

Shannon said,

“I think the simple answer would be yes, but it would kind of be ineffective. When I was in a not a great place and I was in the hospital, one of my colleagues referred to be as the bear [giggle], because I was [giggle]. I was negative and just, like do the job, let’s just plow through things . . . so I mean was professional in terms of communication, but what I think about professionalism as a whole, you know, boundaries and self-care, how you view yourself, how you view others, how you, kind of, complete your entire job, I wasn’t doing that, and it showed. And so . . . yes, I was doing my job, but I wasn’t doing any justice for myself. I don’t think that I was unprofessional to any of my patients, but I definitely, maybe, didn’t take the time as I could have or would have liked to.”

Matt likened this notion of provisional professional . . . something that can’t be sustained without self-care to the image of someone “limping along.” Matt said,

“I think you could limp along for a while but I don’t think that you could completely not practice self-care and be a professional nurse for forty years . . . I don’t think it would last for very long.”

Professional Circumstances that Make Self-Care Education More Relevant

Participants’ answers to the question, if there are personal circumstances that make the need for self-care education more relevant, were conflicted. Half the participants felt that self-care education is needed more in situations where there is a lot of death and tragedy. The other half felt that self-care education is something “important” and is needed in all areas of nursing practice.

Rose felt that nurses who worked with highly vulnerable populations required more self-care education. In the following passage, Rose described how, very early on in her career, she was confronted, “hit in the face,” about her need to “build a self-care arsenal.” Rose said,

“Dealing with people that are very compromised and very vulnerable . . . For me, that was one of the very first, sort of, hits in the face, that I got around, what do I
need to do to preserve myself, to, you know, begin to build my self-care arsenal or toolbox so that I could put my work into perspective.”

Likewise, Dan and Laura agreed that when working with “certain types of patients” and with “special types of tragedy,” greater self-care education is needed. Dan said,

“Whenever there is a special type of tragedy that happens at work . . . [you need to] focus more on supporting each other.”

Laura said,

“[Deep breath inhale] . . . I think . . . so, with gerontology, most of my patients would end up dying.”

Taking into account what Rose, Dan, and Laura described, Collette considered her own self-care practice needs, in comparison to those of her husband’s (who works as a first responder—a volunteer firefighter). Collette said,

“Most of my recent practice is in primary care, and I actually have a husband who is a volunteer firefighter, so he’s a first responder, he’s been exposed to lots of traumatic events, and if I were to compare our needs for self-care, I’m not sure that it’s separated by groups. I think we have a perception that a certain area may require greater self-care . . . but I don’t know if there would be a difference in self-care needs across various organizations or settings or roles.”

Matt echoed Laura’s words, by reflecting upon his own experiences and describing the “emotional messiness whenever you’re working with humans.” Matt said,

“I can think of scenarios in any location, like, I worked in a trauma hospital, in emerg (emergency), to a two hundred people community north of [Name of City/Town], so, I’ve seen people from babies, sick kids, older adults, and I can’t think of scenarios where you wouldn’t need self-care. Like you’re always working with humans, so whenever you’re working with humans it’s a messy situation.”

Interestingly, only Sandi indicated that the need for self-care education might be more relevant for nursing students, since “there needs to be a lot of nurturing of new grads” so they won’t “leave the profession.” Sandi said,

“I think often for new grads particularly, a lot of them will have to end up in med surg (medical surgery) where the load is high and there isn’t maybe a lot of
support. I think there needs to be a lot of nurturing of new grads, cause you want them to have the positive experiences, you don’t want them to leave the profession.”

Consequences of Seeking Emotional/Mental Self-Care Support—“It’s Like a Reprimand”

Although all participants spoke about the importance of self-care education as a protective strategy against occupational stress, burnout, and mental health issues, when it came to seeking care for these issues, many participants said that many students and practicing nurses struggled with stigma and fear of reprimand due to disclosure. One of the study participants, Shannon, told me,

“There’s still a lot of stigma around mental health and we’re not really as progressive as we probably should be. Students don’t want to go to a counsellor because they don’t want to be labeled or perceived as being labelled or having to admit that something’s wrong. They fear whether they are going to be able to be a nurse . . . a good nurse . . . and just speaking for myself, I don’t know if it’s a pride issue but ya, I’ve been so angry at myself because I know anxiety and depression . . . I help people on a day-to-day basis with this, so how could I need [medication and counselling]?”

Similarly, if needing care and support for occupational stress or mental health issues,

Abbey, stated that,

“It feels more like a reprimanded. things like, [spoken in a scolding tone and enacted using air quotes] ‘meetings with the dean’ and ‘making a plan for you’ can happen . . . almost like help is forced on you which often, is not very helpful at all, because it can be embarrassing. You’re so vulnerable. You don’t know who knows what, or what’s happening, or if people are judging you . . . One my colleagues went through this recently, and the manager even came out to the desk and was talking about her [the colleague] with other people, and my colleague going through this didn’t feel [spoken in a sarcastic tone with air quotes] ‘support’ from the manager, and just felt like her personal life had kind of been put on broadcast. That didn’t help her at all.”

Collette remarked,

“When nurses have to take time away from work for sick leave or something related to their mental health, I frequently heard negative statements around that and, those nurses are stigmatized for taking that time . . . I do think that it’s
stigmatized . . . I’ve heard comments about ‘that’s just the go to’, or ‘a way to have summers off’, or that ‘no nurse can work pregnant anymore,’ that they’re all just ‘jumping on the [band]wagon to get summers off.’ This idea that it’s not really a need . . . it’s something that they’re kind of just doing for fun . . . almost like an excuse or something.”

Like nursing, the need for self-care is important in other high-stress occupations where issues of capacity for self-assessment, ability to care for others, capacity to act on others’ behalf and sustainable practice are linked to the professional role. In a paper written by Law Professor Dr. James Jones (2015), the difficulties that “high functioning” professionals (i.e., lawyers, legal students, physicians, and medical students) experience when seeking care for mental health issues were discussed. Reasons, echoed by study participants, were largely attributed to the way that “high functioning” professionals often keep their illnesses or need for self-care hidden. Jones stated that

“they [high functioning professionals] do this because they fear stigma if they are open to others. Perhaps one of the best (or worst) examples of stigma among professional communities is the situation in many states where medical and bar licensing agencies ask applicants intrusive and inquisitional questions about any history of mental health conditions or treatment. Students, who fear they will not be approved for a license if they answer “yes” to these inquiries, will forego the mental-healthcare they desperately need in order to be able to avoid having to report diagnosis of, or treatment for, mental illness. This choice to go untreated can gravely affect them. Thus, stigma has terrible consequences for professionals. (p. 3)

Knowing that a sub-culture exists where high-functioning professionals and professionals in training (such as nurses and students), keep their personal “struggles” and need for emotional or mental support hidden for fear that disclosure would result in discrimination and damage to their studies or intended careers, it is an ethical imperative that professional studies program develop appropriate curriculum to adequately prepare its students for successful and sustainable employment. In the next chapter, following study conclusions, implications as “the power and pedagogy of reflective practice” and
“the power and pedagogy of care,” are further discussed as the goal of self-care education and pedagogical strategies to support learners in self-care practice.
CHAPTER FIVE: CONCLUSIONS AND IMPLICATIONS

“Caring requires paying attention, seeing, listening, responding with respect. Its logic is contextual, psychological. Care is a relational ethic, grounded in a premise of interdependence. But it is not selfless.” (Carol Gilligan, 2011)

This study underlines the multiple identity constructs of professionalism and self-care in nursing, in addition to the challenges associated with teaching and assessing self-care as a professional competency in nursing education. Understanding how self-care is articulated is an important first step toward the development of self-care curricula that properly prepares nursing students for successful self-care practice and sustainable employment. And so, from a nursing faculty perspective, I explored the notion and phenomena of self-care (i.e., the intentional way one takes care of one’s self) as a professional competency in nursing education. Study conclusions suggest that self-care in nursing may be understood and taught through emotionally engaged self-reflection, not as a prescribed set of behaviours or individual task-based activities, but instead, as a pedagogical ontology in the professional care practice of others and with others.

Self-Care as a Professional Competency in Nursing Education

Language constructs (developed through a post-structural analysis of participants’ interview transcripts) informing study findings revealed that self-care is hierarchically structured around age, maturity, and professional exposure to risk and stress, whereas nursing professionalism is hierarchically structured around experience, professional role, gender, emotional stability, education, and employment status. Not only do these findings align with the Butler’s (1990) theory of performativity and the creation of
hegemonic identities, they are consistent with previous research in this area indicating that gender invisibility, interdisciplinary barriers, and educational silos exist between understanding and agreement of professional practice language and behaviours amongst gender diverse nurses, between physicians and nurses, and baccalaureate degree and college-trained nurses (Butcher & MacKinnon, 2015; Kellet & Fitton, 2017; Liberati, Gorli, & Scaratti, 2016).

Within the post-structural analysis, it was interesting to discover how participants’ discourse, as performativity, influenced their own professional identity and that of others. In some cases, participants were acutely attuned to the way that societal norms were subjugating them. For example, in comparison to a physician’s professional role, participants commented “there isn’t the glory [for nurses] that physicians get,” and that nurses were expected to yield responsibility/decision making to the doctor (as evidenced in their acknowledgment of the doctor’s orders, ‘yes doctor, yes doctor’). Similarly, in the way that “nurses need to be put on a priority,” for self-care and how “nurses are on the front line too,” participants commented that there is greater public acceptance that self-care is more urgent in professions such as firefighting, emergency response, and rescue work, policing, and the military.

In other cases, participants were unaware of how their own discourse was subjecting others and how these ideologies shaped the interpellations of the social structures in which they operated (Althusser, 1971/2004). Key examples of this are the way that participants described “the English teacher” or “secretary” as having less responsibility towards public safety than that of nurses, the way that nurses who were “emotionally stable and in control,” were more competent at their job compared to nurses
who were not, the way that experienced and mature nurses were more competent and capable of implementing self-care compared to nurses who were inexperienced or young, and the way that university-trained and part-time nurses didn’t get caught up in “complaining” or “bullying” compared to college-trained and full-time nurses. This notion is very much in line with Keilsling’s (2006) comments that although some people in hegemonic positions may “not always feel powerful, and they, in fact, may not directly dominate anyone,” (p. 261), they do have a role to play in the way that “ideology represents individuals’ imaginary relation to their real conditions of existence” (Althusser, p. 181). Butler (1990) further this idea, that “grammar nor style are politically neutral” (p.xix), by describing the flaws in the use of language to express views that may be perceived as distorted and ostracized. Knowing how one’s identity may be impacted by hegemonic discourse is an important consideration for nursing students. As “nurses are shifting their attention away from institutionalized experiences of illness to a focus on clients [and] health needs in the broader context of their lives . . . they should be aware of how power affects their interactions” (Gregory, Harrowing, Lee, Doolittle, & O’Sullivan, 2010, p. 1).

**What is Nursing Professionalism?**

Metaphors and images of nursing professionalism embodied the nurse as “looking the part” or being “picture-perfect.” Other metaphors and imagery used to depict nursing professionalism included a nurse in her uniform presenting with full name-tag and designation, a capable, empathetic nurse who is engaged in her work and willing to help others, and a nurse who can maintain calmness and convey warmth, despite the surrounding storm. In all of these depictions, the nurse professional presents herself as
happy, cooperative, kind, and self-controlled. This portrayal of nursing is consistent with the “grand narrative about nursing—still predominantly a female profession (Jones & Gates; Snyder & Green) — a story that both nurses and non-nurses tell, it is the idea of ‘the good nurse’” (McAllister & Brien, 2015, p. 79). Again, this entire notion of nurses “looking the part,” is another example of Butler’s (1990) theory of performativity and how pervasive societal norms are reflected not just in the language but also visual art (World War II nursing recruitment poster) is used to construct hegemonic identities. This may be achieved by understanding the performativity of and how language perform and embody ideas in the construction of identity (Butler, 1990; Stock, Sameshima, & Slingerland, 2016, 2016; Spry, 2010).

Words (without metaphors or imagery) used to describe nursing professionalism affirmed the positive values and attributes of an ideal person performing the role of a nurse professional as “good” or “virtuous.” Participants re-stated the College of Nurses of Ontario’s (CNO) and Registered Nurses Association of Ontario (RNAO) professional practice standards and ethics guidelines, and words such as “trust,” “respect,” “integrity,” “ethics,” “morals,” “responsibility,” “accountability,” and “honesty” were at the forefront. Participants also described nursing professionalism as an inherent yet elusive state of “being”—something for which not everyone is capable of, “having knowledge and competence” or “having ethics and morals,” “something one loves to do” and “something mandated” by professional practice standards, guidelines, the College of Nurses of Ontario (CNO). Instead of telling stories about “professionalism,” participants recounted incidents in which nursing colleagues and nursing students who acted “unprofessionally.” Specifically, these stories centered on gender bias-bullying (i.e.,
females nurses bullying both male and female nurses) and student cheating.

**What is Nursing Self-Care?**

When asked *what self-care is*, participants responded with stories of *what self-care is not*. These stories centered on self-care crisis (i.e., mitigating factors and reflective hindsight before and after experiences of personal and professional crisis, occupational burnout, and the need for self-care), stories of caring for others, and stories of emotionally engaged self-reflection. Uncovering the deeper meaning behind these stories, the “disnarratives” and “nonnarratives” supported earlier notions of nursing as an “ethical paradox” and “negotiated identity.” Both these descriptors were in line with the perplexity of a nurse professional as “looking the part,” as what is on the surface, what’s obvious and plain in sight, (i.e., the daily duties and dispositions of a nurse professional) is multi-layered and often hidden.

In addition to sharing stories about what self-care is and is not, when prompted, participants described self-care using metaphors and imagery. Specific metaphors used centered on themes of “kicking off my shoes,” “meeting basic physical needs,” and “balance, and “blindsight.” Where “kicking off my shoes,” furthered the complex interplay of nursing professionalism and self-care as “looking the part,” “balance” and “blindsight” was described as something physical and non-physical. This prompted the idea that something can be hidden in plain sight, as in participants were “blinded” to the negotiated roles they were “performing,” and were only able to “recognize” the “ethical paradox” they were in after they “balanced” or re-adjusted their self-care strategies.

Participants’ illustration of self-care as “meeting basic physical needs,” was fascinating, as it supported Foucault’s (1984/1986) philosophy of caring for one’s self as
a societal duty and social practice, yet it seemed to contradict Maslow’s (2012/1943) hierarchy of needs theory. Where Foucault explained that self-care practices did not just focus on care of the body, and in fact the body was sometimes subjected to intermittent fasting and extreme physical exercise to “reveal the state of one’s soul . . . [in a mode and manner] that was not an exercise in solitude, but a true social practice” (p. 51), Maslow suggested that self-care of the soul (self-actualization) could only be achieved after the basic biological necessities (such as the need for food, water, fresh air, rest, and shelter) were met.

Nurses who were depicted as taking “good” care of themselves (i.e., “exercising and eating healthy”) were no more advantaged (compared to nurses who did not take “good” care of themselves), to describe “entering” deep moments of emotionally engaged self-reflection. In these moments, participants framed their experiences of “livingness” in directional and metaphorical relation to encounters of “stepping away” and “taking time” from something that did not physically exist; they narrated transformative encounters of altered consciousness where they emotionally connected to someone or something greater than their solitary selves. Through this spirit of connection, participants gained a renewed sense of energy, acceptance, purpose, and meaning within their professional roles.

Supporting this study’s conclusions, Blood First Nation scholar Billy Wadsworth (as cited in Blackstock, 2011) explained that,

Maslow’s interpretation of Blood perceptions of human and societal needs are not wholly reflected in Maslow’s final model. Maslow did not fully incorporate Blood First Nation understandings of ancestral knowledge, spirituality, and multiple
dimensions of reality, nor did he fully situate the individual within the context of community (Wadsworth, 2008). For instance, if Maslow had more fully integrated Blood First Nations perspectives, the model would be centered on multi-generational community actualization versus on individual actualization and transcendence. (pp. 3-4).

Terry Cross (as cited in Blackstock, 2011) has reinterpreted Maslow’s hierarchy of needs through indigenous eyes (refer to figure 10) to create the “relational worldview principles” (p. 4). Using this framework, Cross argued,

that human needs are not uniformly hierarchical but rather highly interdependent in nature with cultural values and laws defining how balance is achieved on personal and collective levels . . . [in this way] physical needs are not always primary in nature as Maslow argues, given the many examples of people who forgo physical safety and wellbeing in order to achieve love, belonging, and relationships or to achieve spiritual or pedagogical objectives. The idea of dying for one’s country is an example of this as men and women fight in times of war . . . [and that] believes that spirituality is the unique force differentiating human life from other forms of life, defining our individual and collective experience. (pp. 4-5)

What is interesting about Cross’s (2007) “relational worldview principles,” (which Blackfoot further developed into the “Breath of Life” theory), is that spirituality is not a religious doctrine, but instead, it is a “personally defined force that centers one’s sense of self, community, and world across time” (Baskin, as cited in Blackstock, 2011, p. 5).

This concept of “spirituality” is consistent with this study’s findings, as nurses who
described stories of emotionally engaged self-reflection talked about “stepping into” a protective, transformed state of consciousness (which I’ve called “God’s space”) that invites emotional connection to something or someone greater than one’s self. In God’s space, like Cross’ “breath of life” theory, time and space are relational. Evidence of this protective domain was uncovered in study participants’ stories about “taking time” and “stepping away” as chronotopes of self-care.

**Teaching and Assessing Self-Care and Professionalism in Nursing Education**

All participants stated that the best way to teach professionalism is by modeling the “right” behaviours, whereas self-care was described as “something that is learned but not taught.” When participants were asked if it is possible to be a nurse professional without having “good” or “positive” self-care strategies, after consideration and further “defining” the relationship between professionalism and self-care, in that “self-care lives within professionalism,” all participants remarked that it is not possible to sustain being a nurse professional without engaging in “good” self-care practice. Half of the participants felt that self-care education is needed more in situations where there is a lot of death and tragedy, whereas the other half felt that self-care is important in all areas of nursing. Although all participants spoke about the importance of reflective self-care education as a protective strategy against occupational stress, burnout, and mental health issues, when it came to seeking care for these issues, many participants said that many students and practicing nurses struggled with stigma and fear of reprimand and being perceived as “unprofessional.” Participants also discussed the challenges they faced in teaching and assessing self-care in nursing education, the problems with reflective journaling, and that “assessment is best performed in practice.” These findings are consistent with the results
of another study I conducted that examined the teaching and assessment strategies used in Ontario nursing education programs (Docherty-Skippen, Hansen, & Engel, 2019).

**Implications/Recommendations for Future Areas of Inquiry**

*There can be no knowledge without emotion. We may be aware of a truth, yet until we have felt its force, it is not ours. To the cognition of the brain must be added the experience of the soul. (Arnold Bennett, 1867–1931)*

Knowing that one’s ability to emotionally connect (through self-reflection) with someone or something greater than one’s solitary self proves to be a successful strategy for self-care, has far-reaching implications not just for nursing self-care curricula, but for self-care curricula in all professional education programs where practitioners and trained specialists engage in the “emotional labour” of care (e.g., teaching, medicine, law, clergy, emergency rescue and response, and health and social services). Understanding the role that emotions play in this phenomenon, and how emotions can be powerful catalysts for self-reflection and professional identity development, are areas that require further investigation. Likewise, the pedagogy surrounding reflective practice, that is, the way that learners are taught to engage in self-reflection as an experiential, “lived”/embodied process, and the way that learners are assessed in this process, are important topics for further consideration. Linking back to the literature presented in chapter two and the findings presented in chapter 4, in the following sections, I draw awareness to these considerations, by pointing out the role that emotion (as “emotional labour”) plays in identity, care, and self-care work, in addition to recommendations for pedagogical
coherence (i.e., the alignment of instructional strategy to desired learning outcome) of reflective practice in nursing education.

**Emotions, Identity, and Self-Reflection**

Nursing care and nursing education often include emotionally challenging interactions with patients, family members, and other healthcare practitioners (De Castro, 2004; Smith, 2012). Even within the early phase of their training, nursing students regularly experience the emotional demands of their intended role as nurse professionals (Harrison & Fopma-Loy, 2010; Jack & Wibberley, 2014). Yet within nursing and other professions that “include direct interaction with the public” (de Castro, 2004), emotion has been regarded as an impediment to “rational thinking” and “professionalism,” giving credence to the belief that emotions or feelings “are to be controlled.” (Harrison & Fopma-Loy, p. 645).

Although the ability to “manage” one’s emotions while trying to understand and support other people’s emotions is an important skill in all caring professions (Evans & Allen, 2002), the professional circumstances necessitating emotional labour, in addition to personal stressors, situates nurses at risk of experiencing emotional labour pressures in excess of their capability to manage them (McQueen, 2004). These emotional demands can have a significant impact (such as “burnout”) on a nurse’s ability to do his/her job (i.e., their professional or clinical competence) as well as his/her personal psycho-social well-being (McQueen; Morrissette, 2004). In fact, Hochschild (2003/1983) pointed out, There is a cost to emotion work: it affects the degree to which we listen to feeling and sometimes our very capacity to feel. Managing feeling[s] is an art fundamental to civilized living . . . But when the transmutation [a term
Hochschild uses to describe how private emotion is utilized in the public work environment of the private use of feeling is successfully accomplished -when we succeed in lending our feelings to the organizational engineers of worker-customer relations - we may pay a cost in how we hear our feelings and a cost in what, for better or worse, they tell us about ourselves . . . the penalty becomes a sense of being phony or insincere. In short, when the transmutation works, the worker risks losing the signal function of feeling [i.e., the person may experience emotional dissonance]. When it does not work, the risk is losing the signal function of display [i.e., the outward appears of “emotionally” appropriate feelings] (p. 21).

For example, in order for a nurse to bring “comfort” and “calmness” to an emotionally charged situation in which a patient or family members experience physical, mental, or emotional trauma and distress, she/he may have to display an outward “façade” of emotional stability or control, regardless how she/he might feel personally. This idea, of nurses being “emotionally stable” and “in control of one’s feelings” in support of their patients’ emotional well-being, resonated throughout my participants’ interviews. Nurses described as “emotionally stable and in control” were considered more professional than nurses who weren’t.

In describing the care experience after the death of a newborn infant, study participant Abbey draws attention to the emotional labour that situation required of her. Abbey stated,

“Knowing that the person who is caring for you is also so heartbroken and distraught and going through this with you like, [in a loud tone] I MEAN, NOT OUT OF CONTROL, LIKE CAN’T COPE CRYING but having tears and being respectful.”
Likewise, in describing his work with vulnerable youth who had been abused, the emotional labour involved in Dan’s work is clear. Dan said,

“So I would never lose control, but you empathize and you listen and you support patients . . . I don’t believe you shouldn’t become emotional about your patient situation . . . but you have to understand that you have a role to play there and if you’re too emotionally engaged then you’re not functioning.”

Where emotional labour “centres on creating a desired emotion in another and requires individuals actively to work on their own emotions . . . [and] feelings have to be induced or suppressed in order to present an appropriate outward appearance,” (Hochschild, as cited in Williams, 2013, p. 5) the way nurses and nursing students are “trained” to navigate these emotional spaces is paramount to their ongoing self-care practice and job sustainability.

Identity theorist Epstein (1973) reasoned that because emotions play an important role in the way a person develops his/her sense of identity, by understanding a person’s “true” or “genuine” emotional temperament in response to a particular event or experience (e.g., one that requires “emotional labour”), it is conceivable to influence and reconstruct a person’s self identity (and professional identity) so that he/she doesn’t become emotionally disengaged within their personal and professional roles.

The Power and Pedagogy of Reflection

In my study, all participants cited the value of emotionally engaged self-reflection, as a protective strategy against “burnout,” yet they reported significant challenges when it came to teaching and assessing nursing students in self-reflective practice. Hence, in this final section, recommendations, using guided or collaborative arts-based reflective practices that are pedagogically coherent (i.e., the instructional strategy is aligned to the learning outcome), have been made. Specifically, I challenge
whether the way reflective practice is typically structured and assessed in professional care education programs (i.e., as individual task-based “written” narrative of reflection) is consistent with the goal of enabling learners to “enter and navigate spaces for self-reflection? In other words, should the instruction and assessment of self-care pedagogy be grounded in *lived* and embodied experiential learning? Or, has the academy’s need for “tangible,” “auditable,” “outputs” of learning (i.e., the factual knowledge and information learners describe in their reflection papers) taken away from the value and purpose of reflection for self-care practice?

In nursing and other professional care education programs, reflective journaling is a widely used instructional strategy for students to “to disentangle the various components of professional practice and linking it to the underpinning theories, promoting better understanding and professional growth” (Hubbs & Brand, 2005; Jootun & McGarry, 2014, p. 3). Although Dewey (1933) first described the importance of self-reflection for transformative learning (the concept “transformative learning” was later developed by Mezirow, 2000), Schön (1995) emphasized the use of reflection in the mid 1990’s, as a way to advance nursing practice opposed to the theory-application methods that nursing was traditionally founded in. Over the recent years, increased attention has been given to the “power” of reflective journaling, especially in nursing self-care education, as a “means of self-awareness” (Williams, Gerardi, Gill, Soucy, & Taliaferro, 2009, p. 36). Even a recent New York Times article by Hayley Phelan (2018) describes reflective journaling as “one of the most effective acts of self-care, and also, one of the cheapest,” yet participants in this study indicated that students don’t “buy-in” to the reflective journal process, thinking they’ve “reflected to death,” or, “what they do
actually write is superficial—not very deep.” Although this study wasn’t designed to examine the challenges educators and students face with reflective journaling, what I gathered from study participants’ interviews, was that often reflective journaling was “assigned” as an individual “writing task” linked to students’ course grades. In fact, in her review of the history of reflective practice in nursing, Dr. Sioban Nelson (2013), Dean and Professor of Bloomberg Faculty of Nursing at the University of Toronto wrote,

Contemporary nurses know all about reflective practice. Nursing students journal their practice experience, practicing nurses review their performance and perhaps write practice narratives for performance appraisal, continuing education or practice review. Prizes, awards and nurses’ week activities typically send nurses into narrative mode – it is how expertise is defined and expressed (Nelson, 2004). Finally, for Canadian nurses, the annual registration renewal in some provinces [which is the case in Ontario] involves the explicit exercise of reflection as an annual form of self-review. This is an auditable exercise and records of the activity must be kept. (p. 203). Dr. Nelson further discusses the evolution of reflective practice in nursing, as having moved away from its highly political origin . . . to institutionally governed reflection and the production of practice narratives for employers or regulators. In such instances reflection as competency demands the nurses engages in a particular version of templated narratives, with little room for open or critical discourse. Moreover, there are punitive consequences for non-compliance or unacceptable narratives. There is more than a little irony that institutionalized forms of reflection, which owe so much to radically inspired innovations of educators in the 1980s, now represent confessional and surveillance style discourses” (p. 211)
Much of what Dr. Nelson (2013) discussed, resonated within study participants’ stories, especially in the story of Collette. Collette compared how reflections are now “perceived by students as a waste of time . . . something that wouldn’t benefit them,” versus “when I [she] first graduated, there was a stronger personal component to our reflections.” Collette also agreed that

“we’ve moved away from that [i.e., the personal component to our reflections towards] . . . looking at your professional development needs, so what is the knowledge that I have and what is the knowledge I need, as opposed to pulling it- into the-the nurse as being one whole human.”

Although all participants cited the value of reflection, as a critical component for their own self-care, the fact that they reported significant challenges with using reflective journaling for self-care education is clearly disconcerting. This suggests that the pedagogical issue is not so much related to the type of reflective instruction, but instead, the way that the reflective activity is perceived and assessed in practice. In fact, as a conclusion to her review of the history of reflective practice in nursing, Dr. Nelson (2013) built a case “against the domination of reflection in the assessment of competence in nursing” (p. 211) and remarked about the irony of reflective practice as something “striking” in that it reflective practice was initially “developed to counter instrumentalism being used for promotion, or for student assessment, or for regulatory purposes” (p. 211). How then, can educators “take back” the reflective writing process in a way to better enable learners in “becoming” embodied reflective care practitioners, capable of “entering” and “navigating” “protected spaces” for self-reflection, as part of their own self-care practice? In the following section, I propose the use of guided arts-informed reflective practices for this purpose.
Guided arts-informed reflective practices.

In a 2017 paper by Walji-Jivraj (a Staff Nurse from the Hospital for Sick Children in Toronto) and Schwind (an Associate Professor from the Daphne Cockwell School of Nursing at Ryerson University), they describe nursing as both “an art and a science.” (p. 1). They discuss the way that narrative, as a specific form of art creation, has been used by nurses as a way for them to explore their professional identity and expand their self-care reflective practice. Specifically, they cite:

Literature involving arts in nursing has been used to help recognize and understand thought-provoking situations and to support the process of reflection (Whiteman and Rose, 2003; Robinson, 2007b). Studies show that when nurses engage in reflective practice by using art they can express their inner thoughts and feelings more easily, increase their cultural sensitivity and manage ethical and empathetic dimensions of care more effectively (Whiteman and Rose, 2003; Robinson, 2007b). Studies have shown benefits of nurses using art to reflect on their practice, such as understanding situations, expressing their feelings more willingly, and becoming more sensitive to patients’ experiences (Whiteman and Rose, 2003; Robinson, 2007b). Moreover, nurses reflecting through art may also be encouraged by their narrative experiences with patients, families, and their own thoughts, to identify and discuss their current and future personal and professional development (Walji-Jivraj, 2014).

Just as I used images to prompt different interpretations of my participants’ lived experiences, guided arts-informed reflection may be used an instructional strategy for learners to experience, in its “livingness,” ways to frame and challenge the stigma and
stereotype surrounding the typical meta-narrative of what “self-care is” and “what self-care it is not.” Narratives told through artistic expression reflect “an ongoing embodied process of interpretation of self and experience in which we cannot separate ourselves, our senses, our body and emotions” (Cunliffe & Coupland, 2012, p. 64). Art-informed research and teaching can create different entry points for people to experience and interpret knowledge. As such, the use of this method in identity work has the potential to empower participants in ways that are personally and culturally meaningful (Gorden-Nesbitt et al., 2019).

Reflective arts-based practices have proven to engage learners to critically appraise and articulate their unexplored or unchallenged contradictions, emotions, and tensions that surface in identity and self-care work (Weber & Mitchell, 1996). In pre-service teacher education, reflective arts-based practices that include a component of story-telling (i.e., narrative), have proved to be a successful strategy guiding pre-service teachers towards positive professional identity development and self-care awareness and practice (Izadina 2013; Stock, Sameshima, & Slingerland, 2016).

**Conclusion and Final Thoughts**

The overarching conclusion to this study is that self-care in nursing may be understood and taught through emotionally engaged self-reflection, not as a prescribed set of behaviours or individual task-based activities, but instead, as a pedagogical ontology in the professional care practice of others and with others. Specific recommendations arising from this study are directed toward novel ways (i.e., guided or collaborative arts-based methods) that teach and assess how students enter and navigate protective self-care spaces for emotionally engaged self-reflection. Future studies
investigating self-care in nursing and professional care education should consider the role that emotion plays in identity work leading to professional self-care practices.
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Appendix A: Semi-Structured Interview Questions

1. Where is your practice location (i.e., urban, rural, remote)? What is your area of sub-specialty/interest? How long have you practised as a nurse? How long have you taught nursing in your nursing program?

2. When you think of nursing professionalism, what do you think of? Why? Please explain further. Is there a word, metaphor, image, video, sound, or body action/reaction that you can use to illustrate this concept? Please explain further.

3. When you think of nursing self-care, what do you think of? Why? Please explain further. Is there a word, metaphor, image, video, sound, or body action/reaction that you can use to illustrate this concept? Please explain further.

4. How do you describe yourself as a nurse professional? Where does nurse self-care fit into that description? Do you see these two concepts as linked? Why or why not?
   a. Would this description also relate to your colleagues? Why or why not? What proportion of your colleagues do you see fitting this description? Please explain further.
   b. Would this description also relate to your students entering professional nursing practice? Why or why not? What proportion of your students do you see fitting this description? Please explain further.

5. Is it possible for a nurse to be a professional, yet not have good self-care strategies? Why or why not? Please explain further.

6. Are there certain professional circumstances that make the need for nursing self-care more relevant? (For example, practice location, medical sub-specialty, responsibility/workload). Why or why not? Please explain further.

7. Is there anything further you would like to add?