

**‘Figuring and becoming’: developing
identities among beginning nursing
students**

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Abstract

The contemporary professional context of initial nurse preparation is characterised by multiple and sometimes competing social and historical discourses. It is in this context that beginning nursing students take their early steps on the road to developing identities that will shape their future practice and continued professional development. Unlike much of the existing nursing literature, the study adopts a post-modern perspective towards the nature of identity. Here it is conceived as a relational concept, dynamic and continuously evolving through the production and performance of narratives of experience embedded in cultural and social environments.

This thesis examines, in detail, the stories told by five pre-registration nursing students at points throughout the first year of their undergraduate education with the aim of exploring how emergent professional identities are constructed. The study is grounded in the social constructivist approach that recognises the impact of distinct cultural contexts and foregrounds the embodied processes of meaning-making and agency in the negotiation of identity. The study seeks to honour the voices of students in this process.

Data was gathered through a series of one-to-one meetings with each participant and supplemented with occasional audio diary recordings and the personal statements used to support their pre-course application. The narrative structure and content of 110 bounded stories were analysed using a multi-dimensional approach designed to reveal the changing identity claims made by individuals.

This thesis contributes to understanding of professional identity development in a number of ways. It demonstrates that nursing students begin their nurse preparation with pre-existing and rudimentary images of the profession that serve as frameworks for their interpretation of early clinical and education experiences. Beginning nursing students improvise their identities, telling tales to audiences that include themselves, at the intersection between the Figured Worlds of practice and education. This represents an arena where they author their present and future selves, using individualised and unique stories to buffer conflicts and establish affiliations. Each participant created a rich and detailed compendium of stories that served to positively represent themselves and *'tell'* themselves into nursing.

This small scale study reveals the significant and often untapped potential of nursing students' stories to establish understanding of identity development. As such they are under-utilised educational and developmental tools that have significant potential for enhancing nurse education.

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Abbreviations

BNF - British National Formulary

BSc – Bachelor of Science

CQC - Care Quality Commission

DNAR - Do not attempt resuscitation

GNVQ – General National Vocational Qualification

HCA - Health Care Assistant

MSc – Master of Science

NHS – National Health Service

NMC - Nursing and Midwifery Council

OSCE - Objective Structured Clinical Examination

PGCE - Postgraduate Certificate in Education

RCN - Royal College of Nursing

UCAS – Universities and Colleges Admissions Service

UKCC - United Kingdom Central Council

A Glossary of technical terms is provided in Appendix 1

Chapter 1 – Introduction and Context

Introduction

Being a nurse and nurse educator is important to me. It is not only what I do, but who I am, or rather, who I have become. It is how I identify myself. It is a journey that formally began thirty years ago but which, in reality, probably has no discernible starting point. In 2000, I switched from a direct clinical role to focussing on developing the next generation of nurses. As a proud and passionate nurse, I saw education as a way to contribute to the sustainability and modernisation of a profession that is often constrained by its own history. This thesis seeks to offer fresh insights into the early steps taken by nursing students as they embark on developing a nursing career and forming their professional identities. This study is designed to appraise the experiential stories of five beginning nursing students during the first twelve months of a three-year pre-registration programme. The outcomes of this research offer rich insights into the process of becoming a nurse in the UK in the 21st Century.

This chapter will introduce the context of the study by outlining a brief history of nurse education in the United Kingdom. It will then highlight the current arrangements that require nursing students to engage simultaneously across academic and clinical settings as they embark on their professional preparation. Contemporary issues that form the backdrop for this research and the context within which beginning nursing students take their early steps are then considered. Next, there is a statement of the aims and questions that have shaped the study. This is followed by a brief account of my own professional journey. The intention is to indicate how my own experience has informed what I focus on in the study. The final section outlines the overall structure of the thesis and the nature of the chapters to follow.

A brief history of nurse education in the UK

Nurse education in the UK has been influenced by a number of regulatory developments and policy changes (See Appendix 2). At the inception of the National Health Service, it was

based on a quasi-apprenticeship model with Schools of Nursing established at major teaching hospitals (Bradshaw, 2001). Student Nurses were salaried from the beginning of their 'training' and often developed very close associations with a particular institution (Brennan & Timmins, 2012). Unlike traditional apprenticeships, nurse education consisted of numerous short-term rotational allocations to wards with differing specialities. An emphasis was placed on practical, 'hands on' imitation of established practices in a variety of situations. In addition, experienced senior nurses provided on-site classroom-based teaching. Significant amounts of learning involved the 'trickle down' of knowledge, practices and values from senior nurses to junior students (Melia, 1987). Assessment was comprised primarily of ward-based practical tests. In the post war period, two statutory levels were established with 3-year preparation leading to Registered status and 2-year preparation leading to Enrolled status. In 1985, the Royal College of Nursing published the Judge Report which called for the introduction of a broader curriculum (to include relevant aspects of sociology and psychology), a move to higher education and a change in student status (RCN, 1985).

In 1986, the regulatory body for nurses and midwives (UKCC) published '*Project 2000. A new preparation for practice*' designed to fundamentally change how nurses were prepared and implementing many of the Judge Report's recommendations (Fulbrook et al, 2000; RCN, 1985). No longer employed by hospitals, nursing students became educationally-supernumerary, working in practice settings without being part of the complement. The intention was that they would be recognised as learners rather than as workers (Ousey, 2011). Education provision switched to Higher Education Institutions, principally the Post-1992 universities, and the theoretical component was increased to 2,300-hours within a 3-year programme. This was delivered at a minimum of Level 4 (Diploma). In addition, students had to complete 2,300 hours of clinical practice in order to register with what became the Nursing and Midwifery Council (NMC). All students were enrolled onto a 1-year Common Foundation Programme before specialising in Adult, Children's, Mental Health or Learning Disability Nursing for the remaining 2-years. Some universities that began offering degree courses in nursing in the 1960s subsequently expanded their provision with the introduction *Project 2000* (UKCC, 1986).

In 2004, the newly formed NMC published the *Standards of proficiency for pre-registration nursing education* in order to establish, in a single publication, guidance for education providers and defining the overarching principles of nursing practice (NMC, 2004). This was superseded by the Standards for pre-registration nurse education (NMC, 2010) which included in Section 2, the *Standards for competence* which must be included in the provider's '*degree-level competency framework*' (p7). These were introduced in order to enhance clinical skills competence in the absence of a single national approach to practice assessment (Bradshaw & Merriman, 2008). While competence-based nurse education has been introduced in the UK and internationally, there remains a lack of consensus concerning the definition of clinical competence (Yanhua & Watson, 2011).

Increasing European and international alignment in nurse education during the first decade of the new millennium resulted in the NMC declaration in 2008 that the minimum academic award should be a bachelor's degree. This saw the discontinuation of diploma level programmes and progression towards an all graduate profession at the point of registration. These developments have occurred amid ongoing debate concerning a would-be nurse's fitness for practice and purpose. This has been informed and influenced by changes in social demographics, disease epidemiology, treatment technologies and health economics alongside increasing public expectations and reasonable demands for high quality personalised care (RCN Policy Unit, 2007). The large number of stakeholders (health consumers, service commissioners, service providers, education providers, students and the profession as whole) means this debate continues to form the backdrop for contemporary nurse education in the UK (Mannix et al., 2014).

Contemporary challenges for UK nurse education

Since the inception of the NHS, there have been considerable changes in the roles and functions of nurses. This includes activities previously carried out by medical practitioners. As triage, diagnosis and medicines prescription become part of Advanced Nurse Practitioner roles, so activities such as history-taking and venepuncture are increasingly considered part of core nursing practice (Shape of Caring Advisory Group, 2016). Simultaneously, unregistered healthcare support workers have been given increasing responsibility for the

provision and coordination of fundamental care (Griffiths & Robinson, 2010). The new Nursing Associate role, located between support workers and registered nurses, is being introduced to provide a formal pathway for development rather than the informal role drift that has occurred. While enhanced collaboration across and between professional groups and increasing inter-professionalism has considerable potential benefits for patients it has also resulted in role confusion and the blurring of boundaries which can be particularly challenging for beginning professionals (McNeil et al., 2013; Niezen & Mathijssen, 2014).

In 2012 Nursing became a graduate entry profession in the UK. Diploma level courses were discontinued and all new and revalidated courses were offered at Bachelor's or Master's degree level along with NMC registration. This represented a further step towards achieving the pan-European standardisation and harmonisation whilst also seeking to ensure effective care provision and workforce sustainability in the 21st Century (Davies, 2008).

Competing discourses about the significance of this development have resulted in a decade of debate played out in the nursing literature and the public arena. Some view nursing as a practical vocation '*unworthy of academic study*', while others insist that nurses need detailed knowledge and skills to make health-care decisions and provide high-quality care (Fealy & McNamara, 2007; Stacey et al., 2015). Recent international research established that every increase of 10% in graduate nursing numbers was associated with a 7% reduction in a hospital's mortality figures (Aiken et al., 2014). Despite this growing evidence, there is a concern, played out very publically in the media, over the perceived correlation between increasing professionalisation and a decline in care standards and nurses' compassion (Chapman & Martin, 2013; Hall, 2004).

Key stakeholders including those who commission and provide nurse education (Burke & Harris, 2000) have sought to make a case in the face of what has been described as a '*simplistic and erroneous explanation*' of perceived instances of poor care (Willis Commission, 2012, p43). At the heart of this is a concern with the professionalisation of nursing and a division over what the 'core' identity of the nurse should be (Baxter, 2011). The public image means that nursing, much like medicine and teaching regularly finds itself part of a wider political discourse, particularly when there is capital to be made from

debates about its contribution and value to the state (Krejsler, 2005). During the data collection period of this study, the UK Parliamentary Electoral campaigns of all major political parties made manifesto pledges concerning health services in general and an increase in nursing numbers in particular.

These contemporary influences on the personal and professional identity of the nurse have informed the most recent policy guidance on education and preparation. Health Education England, the nationwide organisation responsible for workforce planning, education purchasing and provision for all health care professions is focussed on *'attracting and recruiting the right people to the education and training programmes we commission'* (Willis, 2015, p10). What constitutes the 'right people' continues to inform both popular and professional debates and influence the choices of potential recruits (Eley et al., 2012; Mazhindu et al., 2016).

As a consequence, there is an increased interest in the values and qualities of nurses, particularly among those at the very beginning of their careers. Values-based recruitment (VBR) has been widely introduced for employer organisations seeking to reassure themselves and the general public that care expectations are being addressed (Miller & Bird, 2014; Rankin, 2013). While there is no evidence that recent concerns have involved nursing students (Dean, 2014), values-based approaches are increasingly being employed in pre-registration recruitment and selection processes. Values-based recruitment assumes that a necessary character and quality should be established before someone is regarded as a candidate for nurse education. Typically the values informing new entrants to the profession remain those of care and person-centredness with which nursing has historically been associated (Eley et al., 2012; Tuckett, 2015).

Beginning nursing students starting out on pre-registration programmes, therefore, find themselves at what has been termed *'a complicated nexus between policy, ideology and practice'* (Stronach et al., 2002, p109). They are required to learn effectively in both academic and clinical settings, whilst balancing the roles of 'learner' and 'worker'. In 1987, Melia referred to this situation as *'part of the nursing folklore'* (p54) where Student Nurses were expected to traverse the worlds of education and practice with two alternative

versions of nursing. Unfortunately, changes in both service and education provision over the intervening thirty-year period seems broadly to have failed in resolving this dichotomy (Newton et al., 2015; Solvoll & Heggen, 2010). Students are still confronted with contrasting cultural routines and practices in both clinical and academic settings. Vexingly, for the beginning nursing student, they are required to operate in situations and contexts that present differing and sometimes antithetical values (Newton & Darbyshire, 2016). In this narrative inquiry, Figured Worlds theory, developed by Holland et al. (1998), has been adopted as a theoretical framework with the capacity to explore the diverse constructions of identity (Bennett et al., 2016). Figured Worlds are social and cultural constructions, populated by recognisable characters engaged in meaningful acts with contextualised value. They are '*realms of interpretation*' that provide a means of coming to understand the socially organised and reproduced contexts of identity development (Holland et al., 1998, p52).

Relevance of this research

Interest in better understanding the ways in which identities are established and negotiated has developed alongside an appreciation of the potential influence they have on nurse effectiveness. Identity concerns how one sees oneself and affords a sense of personal control and free will (Adams and Marshall, 1996). In addition, identities generate meaning and direction from experience, establish purpose in action and achieve unity within groups (Iedema & Caldas-Coulthard, 2008; Jenkins, 2008; McAdams & McLean, 2013). Importantly they can also enable one to recognise future possibilities in the ongoing process of becoming (Adams and Marshall, 1996). According to Holland et al. (1998), they are '*the means through which people care about and care for what is going on around them*' (p5).

While every nurse has been a student and has their own 'tales' to recount, individual reactions to events are unique. The process of establishing new or emerging identities can be challenging and stressful, particularly when faced with competing and contrasting social contexts (Slay & Smith, 2011). It is, therefore, important to attempt to understand how beginning nurses develop their identities in the complex social environment described above. The development of competent, capable nurses is of paramount importance if

individuals are to *'provide essential care to a very high standard and provide complex care using the best available evidence and technology where appropriate'* (NMC, 2010, p4).

Undertaking research into emerging and developing identities is a way of illuminating the often unseen experiences of beginning nurses and the discourses they encounter. It can render explicit what is deeply meaningful to the individuals, even at the very outset of their professional career (Timostuk & Ugaste, 2010) since this shapes their understandings about practice and directs their action in the continued development of knowledge and skills (McCarthy & Moje, 2002). As a result, the mechanisms by which identities are formed and transformed is of increasing interest to those involved in the contemporary nurse education (Andrew, 2012; Cowin et al., 2013; Hershey, 2007; Johnson et al., 2012; Worthington et al., 2013).

For nurse educators, any insights into the process of identity formation offer opportunities to evaluate and enhance teaching and learning practices and experiences. Clements et al. (2016) argue that little attention has been paid to the early stages of professional identity development. They conclude that nurturing professional identity should be a priority for educators in both academic and practice settings to promote retention in the short and longer term. The lack of standardised data sets limits the accurate calculation of attrition rates reported in some places to be at 40% (Clements et al., 2016). These are typically highest in the early stages of a programme as new students begin to comprehend the realities of the choices they have made, the knowledge they will need to master and the skills both technical and interpersonal that they will need to acquire. Contemporary longitudinal research has mapped non-linear changes in nursing students' orientation towards the profession over time (ten Hoeve et al., 2017). Most worrying are the instances where dissonance between students original personal values and those encountered in practice result in withdrawal and considerable individual emotional distress (O'Donnell, 2009). Having recognised the problem there are growing calls for research to explore and understand in detail these processes, beginning at an individual level (Cowin & Johnson, 2015; ten Hoeve et al., 2017).

Research aims and questions

The overall aim of this study is to better understand the way in which beginning nursing students develop their emergent identities through the self-authored stories of the early steps in their nursing career. Much of the research to date has concerned the development of professional identity among nurses at the point of registration (Björkström et al, 2008; Gerrish, 2000; O'Shea & Kelly, 2007; Sandvik et al., 2015; Thrysoe et al., 2010). This marks the point of formal social recognition as a nurse but does not represent the genesis of the process of becoming a nurse which is likely to begin much earlier. To examine this, some studies have addressed specific watershed moments such as first placement experiences (Andrew et al., 2009; Leducq et al., 2012) or early choices about branch specialisation (Bradby & Soothill, 1993). In each instance, the focus is almost exclusively on role development in clinical practice (Felstead, 2013; Lewis, 1998) and, with a limited number of exceptions (Rees et al., 2015), has tended to lack narrative detail. By answering the following questions, this study seeks to foreground the individuals' voice and explore the numerous complex early formative and potentially transformative pre-inaugural experiences that rarely appear in the research literature.

1. What do beginning nursing students narrate as significant experiences, events, and interactions during the first year of a pre-registration undergraduate programme?
2. What are the forms and functions of stories told by beginning nursing students as they develop their emerging identities?
3. What are the identity claims that beginning nursing students make? How do these change as they progress through their first year of a pre-registration undergraduate programme?
4. What are the Figured Worlds beginning nursing students inhabit?
5. How do beginning nursing students go about figuring their identities in these worlds?

My own story

Before setting out to answer the research questions listed above and consider the stories of others, it is necessary and appropriate to elaborate my own reflexive autobiography

(Connelly & Clandinin, 2006). This serves to illuminate the worldview that informs my nursing, education, and research practice as well as position me in relation to the study and the experiences of the participants.

My aim in telling one of my own stories is to engage in sharing and to represent to the reader the '*interpenetration*' of spheres of experience, mine and the participants (Clandinin & Connelly, 1988, p281). In doing so, I seek to demonstrate my appreciation and acknowledgement of subjectivity, as way of achieving a reflexive standpoint. I am conscious that, as a nurse myself, my own experiences influence what and how I interpret the experiences of others. I use the story below to illustrate the relationships I sought to establish with people I cared for in my clinical career, the students I support in my education career and the participants' who aided me in this research.

I have come to appreciate that this story also serves as a means of representing my own professional identity to the reader. While I have provided a brief chronology of my career, storying the central experience provides an opportunity to show the reader who I am and what is important to me as a nurse and educator. In doing this, I am holding a mirror up to myself.

I became a Student Nurse at the age of 18. This is when I started what was at the time, one of only a few pre-registration degree courses. I frequently had to explain why I was 'doing a degree in Nursing' to those who believed it was unnecessary. Many did not recognise the value of a degree and thought it only necessary for those who intended to become nurse managers. After the initial insecurities of being an 18-year old, in a minority and looking to better understand who I was and what I was to become, being a nurse has become how I think of myself. I am aware that I see the world through the eyes of a nurse. When I made the challenging transition from clinical practice to education, it was returning to the core of what made me a nurse that provided a foundation for building a 'new' identity and starting a fresh chapter in my career and life story, a consistency identified by others in their reflective narratives of becoming professional educators (Chan & Schwind, 2006; Lindsay, 2006; Young & Erickson, 2011).

I had worked for seven years at a local hospice with people, colleagues and those I was caring for, who taught me what it was to be a good nurse. Sitting with someone as they die, sharing critical times in people's lives showed me what is important about the work that nurses do. It was also here that I came to more formally appreciate my subjectivist interpretation of social reality. It provided a setting where I could spend time listening to what people wanted to tell me, stories of their lives and experiences, their work, their families and the details that made them unique. All of these are embodied in my story of Raymond.

Raymond is with me all the time, as a point of reference for both what is important in practice and what I feel I need to be as an educator. Raymond was big, physically and intellectually. He was trapped in a body that did not work for him or even allow him to exercise simple and taken-for-granted controls over his environment but his voice, his personality and his sense of humour certainly did. Living with an extreme form of Motor Neurone Disease, Raymond could be cantankerous, insistent and hurtful and he often needed to be although this was never driven by spite. He faced what many would consider an intolerable existence, dependent upon his wife, daughters, and carers for 3 of every 4 weeks to then be relocated to the hospice for regular respite care. It was hard work caring for him and many of the team avoided being involved or limited their contact.

Picky, fussy and mischievous, he would tell the same stories of his working life as a scientist during each stay. He would put efficacious junior doctors in their place and fix people with one, slightly wonky eye. When amused he would laugh, inevitably prompting a coughing fit and a worrying change in his colour. But Raymond needed to be all these things because that was who he was. When I figured that out, we established what I still consider to be one of the most effective and fulfilling professional relationships I have had as a nurse. Both of us would perform our identities through the stories we exchanged in the context of our 5-year working relationship. It was only talking to his daughters at his funeral that I came to appreciate how much he too had valued these opportunities.

My career changed direction not long after he died. I was looking to consolidate myself as a graduate nurse, building on nearly ten years of clinical experience and moving into nurse

education, and Raymond came with me. Like many other nurses who move out of principally clinical roles, I needed time and opportunities to renegotiate my evolving professional identity (Findlow, 2012) . I regularly retell myself the story of working with Raymond as this serves to rehearse and remind me of the nature of my identity as a nurse. I also tell the story to students as a means of articulating the characteristics of the therapeutic relationship as well as presenting myself/performing my identity as a credible nurse and educator. It acts as an example of the elements of narrative competence, attention, representation, and affiliation, which embody the professional artistry and ethical practice that I seek to convey in my teaching, my research and my own reflective writing (Charon, 2007).

Thesis structure

The remainder of this thesis is structured into nine chapters. Having contextualised the research study here, Chapter Two provides a review of the literature concerning identity theories and the notions of professional identities in the context of nurse education. Chapter Three explains and justifies the narrative methodology and research methods used in this study. It provides a description of the practical steps undertaken as well as an illustration of, and support for, the design choices made. Chapters Four to Eight contain the stories and analysis of each of the five participants in a format designed to both honour their voices and provide evidence of the detailed scrutiny required for robust analysis. The aim is not to present generalizable findings but to reify the stories shared by a small number of beginning nurses. Chapter Nine is structured around the research questions and Chapter Ten contains observations drawn from the detailed analysis of the participant's stories and recommendations for future research. It also contains a brief evaluation of the research, of me as a researcher and the implications for my own future education and research practice.

Conclusion

This chapter has provided an overview of the historical and cultural context for the study as well as a brief insight into the ongoing professional and social discourses. It included a case for developing a better understanding of the ways in which beginning nurses negotiate their emergent identities and outlined the structure of this thesis. In addition, it contained a brief

personal narrative intended to introduce the nature of the research undertaken and elaborate why I was curious to explore the self-narrated stories of beginning nursing students as they developed their professional identity. The next chapter will report on the literature review undertaken. This serves to illustrate existing understanding of key concepts and establish the theoretical and philosophical basis for this research.

Chapter 2 - Literature review & Theoretical perspective

Introduction

The notion of identity, including professional identity in nursing has interested educators and researchers over the past four decades. A recent review of the contemporary nursing literature highlighted a lack of clarity in the theoretical origins of the concepts and a distinct lack of agreement about their meaning (Johnson et al., 2012). A typical example of this confusion appears in a paper by Hao et al. (2014) who claim professional identity *'is'* professional self-concept (how students and nurses perceive the profession) *'or'* the values and beliefs that guide practice. This is not a situation unique to nursing as similar uncertainty is found within the wider qualitative literature (Smith & Sparkes, 2008). As a consequence, the notion of identity is *'promiscuously mingled, producing a good bit of confusion and ambiguity'* (Holland & Lachicotte, 2007, p101).

In a 2012 literature review of professional identity development within Higher Education, Trede et al. established that, while the concept had been explored by a number of disciplines, very few of the papers provided clear definitions of professional identity as a concept leaving the reader to assume a self-evidence based on personal experience. The most recent attempt to define professional identity in nursing, based on a rather generic concept analysis, suggests that it *'guides how nurses think, act and interact with their patients and compare and differentiate themselves from other professional groups'* (Dehghanzadeh et al., 2016, p1113) There is general agreement that it is a complex and multi-dimensional concept influenced by social, cultural, historical, political and organisational considerations (Öhlén & Segesten, 1998). The broad thrust of descriptions agreed that professional identity was concerned with a way of being and means of learning and making sense of experiences, be they occupationally related or not. Sims (2011) suggests that *'precision'* is *'elusive'* and its definition remains *'uncertain'* (p266).

The initial aim of this chapter is to achieve some clarity by untangling how identity and professional identity are employed within the literature in relation to nursing students. A review of the considerable material published on this topic is presented in broad themes of identity as collective societal image, the consequence of socialisation, as self-concept, and to a limited extent, as trajectories. Perhaps surprisingly, very little nursing specific literature has considered identity constituted in discourse and so it has been necessary to consult a wider body of material. Restrictions on space preclude a detailed consideration of the full gamut of theories and neither will this review attempt to wrestle with contrasting definitions. Instead, the aim is to summarise those frameworks, relevant literature and student experiences which have informed the research questions and subsequent data collection and analysis activities.

The second part of the chapter will address the post-structuralist approach that represents the philosophical approach adopted for this research. The understanding of identity towards which I shall be working during the earlier sections of this chapter is one of becoming through narrative. I conclude with a consideration of Figured Worlds, a theoretical framework with foundational elements drawn from the work of Bourdieu, Vygotsky, and Bakhtin (Holland et al, 1998).

Identity as a collective societal image

Frequently, the notion of professional identity refers to 'a' professional identity; the collective image that serves as a heuristic (characterisation) for society, enabling people to have a sense of who a particular group are and what they do. This is particularly so when there is public uncertainty about professional complexities (Buresh & Gordon, 2013; Davidson, 2015). Nursing has historically been framed by various common public portrayals that may have proved entertaining for many but represented a significant impediment to the development of the nursing profession (Huston, 2014). It is this societal image conveyed through various media that beginning nurses are exposed to even before they contemplate making their career choices (Sand-Jecklin & Schaffer, 2006).

Historically, nursing recruitment has benefitted from a positive cultural image. Nursing is generally regarded as a worthwhile occupation with a level of social capital, and nurses as people with integrity, who are hardworking and caring (Huston, 2014). An affinity with this virtuous cultural image (nursing and nurses embody the virtues of care, compassion and altruism), along with the stereotypical understanding of nursing, has a strong influence on the decisions made by would-be nurses (Price et al., 2013). Association with and adoption of a collective group or social identity reinforces the integration of group and personal characteristics. These serve to motivate the actions of students required to overcome the hurdles to group membership, particularly concerning their role in clinical practice (Spouse, 2000).

The societal image of nursing has long been dominated by contrasting, often polar, representations of the profession and individual nurses (ten Hoeve et al., 2014; Huston, 2014). While many embody positive characteristics of caring and committed professionals, there are numerous stereotypes that might negatively impact on the self-esteem of the profession (Fletcher, 2007; Takase et al., 2002) and individual practitioners (ten Hoeve et al., 2014; Takase et al., 2006). Popular images are often stereotypical and rooted in a historical predisposition towards caring as non-technical 'women's work' in contrast to the masculine activity of medicine (Takase et al., 2006). These stereotypical images have proved remarkably durable, not least because of the relative absence of a competing counter-discourse that advocates the true nature and complexity of modern nursing practice (Willis Commission, 2012; Kelly et al., 2012). It is on this basis that many nursing students initially construe the nature of nursing work and their emergent professional identity (Price et al., 2013). However, research exploring influences on career decisions indicate that few if any, potential nursing students acknowledge the direct impact of stereotypes on their own identity (Larsen et al., 2003). The findings of Sand-Jecklin & Schaffer (2006), in one of the few studies undertaken prior to classroom or clinical experience, highlighted how beginning nurses disassociated themselves from the stereotypes. Where family or friends expressed these enduring lay images, Day et al. (2005) found discontent among nursing students resulting from the clash with their rapidly acquired '*new professional values*' (p642).

Cook et al. (2003) established that nursing students, on their very first day in a university setting, had already developed rudimentary, if not always practically consistent, notions of nursing and their potential future roles. Sometimes referred to as 'idealised' views, these serve as a basis for initial choices and form an important part of the milieu of becoming. The primary factor identified as influential in choosing a career in nursing relates to its definition as a caring profession (Alpers et al., 2013). Numerous studies have consistently identified that while complex motivations are at work, the personal aspiration to care and make a contribution to the community is significant (Day et al., 2005; Mooney et al., 2008; Wilkes et al., 2015), are consistent across different cultures (Halperin & Mashiach-Eizenberg, 2014) and throughout the pre-registration and early career phase (Fagerberg & Kihlgren, 2001). Limits to the understanding of what care is or the specific conceptions of care and caring (Wilkes et al., 2015) suggest that, while it is important for the self-image of potential nurses, the practical implications and details may not have an influential impact. Age and gender variations account for some variance (Haron et al., 2014). While there is a constellation of motivators influencing decisions including pragmatic and material factors (Jirwe & Rudman, 2012), altruistic personality traits have been advanced as an explanation (Eley et al., 2012) impacting upon the way the person sees herself or himself in present and future contexts.

Results from these various studies highlight the fact that students do not begin their pre-service programmes as '*blank slates*', devoid of pre-existing understandings (Hershey, 2007; Izadinia, 2013). They may not have experienced the successes that trigger what it 'feels' like to be a nurse but they have already begun their journey towards constructing a professional identity (Sandvik et al., 2015). Within the nursing education literature, aspirations and intentions are often described as dreams representing an idealised and future orientated position that is significantly desirable to the person (Spouse, 2000; Williams et al., 1997). This allows the individual to focus their effort on a goal even if this is not a realistic representation of their future or the role they may adopt.

Social images of nursing abound and show a consistency across national boundaries (Kirpal, 2004). These may be characterised as constructive or destructive. While they may not always be acknowledged as a central influence on nurses' own perceptions of their

profession, it is clear that early conceptions of nursing play a role in very early professional self-image (Brodie et al., 2004; Milisen et al., 2010) often as a starting point for understanding their initial learning experiences.

Identity as a consequence of socialisation

Professional socialisation concerns the process by which a beginning nurse acquires the knowledge and skills, values and beliefs of the professional group. It has been closely associated with the development of professional identity and therefore has been of consistent interest to nurse educators. Much nursing research has sought to examine the effects of role-modelling and the emulation of traits that perpetuate images and practices among those new to a particular social situation (Brown et al., 2013; Clouder, 2003; Curtis et al., 2012; Melia, 1987). It is often regarded as an essential process necessary for establishing a sense of belongingness that contributes to the effective integration and retention of newcomers to a professional group (Houghton, 2014; Willetts & Clarke, 2014).

Simpson's (1979) longitudinal study of eight cohorts of American nursing students in the early 1960s highlighted the multidimensional processes that result in the internalisation of norms, customs, and ideologies. These preserved the so-called 'core values' which were regarded as fundamental and, in many ways, definitive of nursing practice informing the characteristic behaviours and identity descriptors of the nurse (caring, integrity, person-centred, ethical practice)(Burkitt et al., 2001; Larson et al., 2013). The findings highlighted the significance of an emerging role identification; the importance of taking the label of Nurse as an identity and establishing group affiliation.

While the significance of how a person feels about herself or himself as part of a group has informed subsequent sociological theories of identity development (Burke & Stets, 2009; Turner, 2013) early explanations of identity formation were often understood in relation to processes of power and conformity (Melia, 1987). The enduring hierarchical nature of many clinical health care environments means these drivers remain significantly influential. As a nursing student comes to recognise the role expectations of others (fellow nurses, patients, and medical staff) they seek to reciprocate these in order to fit in. Recent research has

established that this often occurs even when these expectations do not align with the student's own personal views or the espoused values from the university (Levett-Jones & Lathlean, 2009). In order to manage their vulnerability and uncertainty, beginning nurses frequently adapt or 'realign' to the team or institutions values (Curtis et al., 2012). Through this repeated interactive process individuals construct a socialised professional self-view that is consistent with the prevailing discourses.

The clinical learning environment is often considered to be where students are '*socialized into the profession*' (Hegenbarth et al., 2015, p304). In most nurse education systems, students spend considerable time in these learning venues, recognising them and their mentors as critical in their professional socialisation (Myall et al., 2008). Unsurprisingly, environments with which students are most satisfied provide what are perceived to be the best learning experiences, a feature which is consistent internationally (D'Souza et al., 2015; Dunn & Hansford, 1997; Henderson et al., 2012). Positive learning experiences enable students to engage with practical aspects of the nursing role, in an environment that values them as individuals (Papathanasiou et al., 2014). They create a culture that clearly demonstrates a willingness to 'invest' in students (Hegenbarth et al., 2015) whilst supported by knowledgeable and committed mentors (Shakespeare & Webb, 2008). Marañón & Pera (2015) in their ethnographic consideration of the impact of theoretical and practice training components, identified, as much previous research has, that the clinical practice mentor has a key and influential role in the degree to which the experience is valued but that the central challenge in forming a professional identity lay in the integration of theoretical ideals and practical realities.

Longitudinal studies have been used to reveal some of the most interesting changes associated with the process of socialisation. The results do not always help to clarify the situation. Mackintosh (2006) painted a rather disconcerting picture regarding the changing attitudes towards the caring aspects of a beginning nurse's role. Between Years 1 and 3 she noted a 'loss of idealism' as students focussed on their ability to cope with challenging situations. Bolan & Grainger (2009), investigating changing professional perceptions, suggested that over the same timespan students developed an increasingly positive image of nursing even though this declined slightly during Year 1. By the end of Year 3 Maben et

al., (2007) established that idealised views of practice had been re-established and provided a springboard for the transition to registered nurse. In combination, these results emphasise the complexity and variability of factors likely to impact on each individual's identity.

One of the most illuminating explorations of occupational socialisation among nurses in the UK was conducted by Melia in 1987. This revealed the foundational problem, reported widely in the subsequent literature, of a dichotomy between the '*ideal*', academic and the '*real*' practice world (Adams et al., 2006; Clouder, 2003; Newton et al., 2015). Contrasts between the classroom segment of nurse preparation that focuses on professional values and the practice segment that prioritises '*getting the job done*' results in nursing students experiencing two versions of nursing. Some suggest that rather than resolving this over the past 4 decades, the increasing professionalisation and intellectualisation of nursing has maintained and, to an extent accentuated this dichotomy (Stacey et al., 2015). The consequences for the student of confusion and anxiety, personal disappointment and professional dissatisfaction, threaten the likelihood that they will develop an identity that is consistent across both settings (Maben et al., 2007).

Professional socialisation in the nursing literature often regards identity as a consequence of a process. Socialisation internalises practice values and establishes an identity that is characteristic of a professional nurse, understood with reference to the practice community alongside the person's own experiences or self-concept (Willetts & Clarke, 2014).

Identity as self-concept

An alternative stream of research has addressed the psychological construct of professional self-concept, the majority building on the seminal works of Goffman (1959), Mead (1934) and Erikson (1968). Erikson modelled human development as a transformation resulting from the resolution of a number of psychosocial dilemmas (Illeris, 2014). The significance of successful resolutions was the achievement of a coherent and consistent identity that persists throughout adulthood and which some might be considered a person's 'core identity' (Gee, 2000). While post-structural conceptions reject these essentialist notions of objective identity, it has proved appealing since it represents an apparently achievable

outcome and a pathway of development that can be measured and manipulated to improve both practice and academic outcomes (Gemeay et al., 2013). Postmodern views of the *self* seek to retain the notion of the 'authentic' whilst acknowledging the fragmentation and 'decentring' of 'fluid' societies (Bauman, 2007) that result in a creative potential for self-definition.

Within much of the nursing literature, the term 'self-concept' is often used interchangeably with 'self-esteem', 'self-identity' and 'self-perception'. Specific notions of 'professional self-concept' are associated with some uses of 'professional identity' as the 'identity of a profession' (ten Hoeve et al., 2014, p 297) but frequently address reflexive notions of what it is to be a nurse. Researching and writing about nursing self-concept over the past 15 years, Cowin (2001) has consistently operationalised this as a link between the inner thoughts of the individual and their experiences of the external world (Cowin et al., 2008). Emphasis is placed on the description and evaluation of the self at an overarching global level and at a domain-specific or professional level. Contemporary understandings of self-concept recognise its dynamic, multidimensional and cognitively constructed nature (Arthur & Randle, 2007) and have sought to exploit its predictive potential. A positive professional self-concept is represented by emotions and experiences that enhance the way in which the nurse views herself or himself 'as a nurse'. As an empirical tool, it has been positively associated with initial career choice (Larsen et al., 2003), improved graduate retention (Cowin et al., 2006) and higher levels of job satisfaction (Cowin et al., 2008).

A desire to both measure and subsequently influence professional identity has resulted in the continued development of tools and instruments. Within the literature, there is growing reference to *Professional Identity in Nursing* (PIN), a measurable entity that can be used to evaluate an individual's suitability for pre-registration nurse education (Mazhindu et al., 2016). This frames professional identity as socially owned and socially constructed and illustrates the increasingly normative nature of some of the discussion in the nursing literature in response to recent high-profile failings (Francis, 2013).

Arthur & Randle (2007) are critical of self-concept research that fails to locate a theoretical position but are also concerned at the preoccupation with descriptive studies. This trend has

continued (Angel et al., 2012; Kelly & Courts, 2007), possibly as a result of an increasing pressure to use evidence-based practice methods. This is clearly illustrated by the growth of professional self-concept studies being undertaken by nurse researchers working in non-Western (Eastern) settings. Eastern notions of the self differ considerably from those outlined above and yet, the hegemony of empirical, evidence-based practice has seen the application of post-positivist conceptions (Hao et al., 2014) over traditional notions. The effects of globalisation on healthcare and nursing have seen a 'grafting' of Western humanist discourse in Singapore, Japan and most notably in Hong Kong (Parker, 2005). There remains, however, a strong cultural gender discourse that alongside broader cultural beliefs have resulted in differing conceptions of nurses and nursing.

One of the apparent paradoxes in Western considerations of identity is the dynamic tension between similarity, or what we share, and difference which acts as the basis of individuality (Bamberg, 2012; Lawler, 2014). Group affinity and self-categorisation frequently employ what Bleakley (2011) refers to as '*selfsame*': the tendency to identify with '*my*' specific and bounded group, particularly in a multi-professional context such as health care. An unfortunate potential risk of this approach is an assumed superiority and the reinforcement of accepted hierarchies, and divisions (Finn, 2008). The emphasis is on establishing an apparently stabilised sense of professional self, tested variously through the act of being recognised as a particular sort of person by the group and by others.

Alternatively one might come to understand and recognise oneself and one's group identity through a focus on the difference (Bleakley, 2011). Here the contrast with '*others*' is used as a means of establishing distinctions and uniqueness, that the identity of self is defined in relation to a non-self. A Western focus on individuality often results in the accentuation of differences to the point that they become defining characteristics. This should be understood not simply in terms of single and discrete occasions but as a constant stream of interactions with key actors in changing contexts: doctors, health care/nursing assistants, patients and experienced nurses/mentors in clinical contexts, tutors/lecturers and fellow students in the academic setting. These differences are not innate but are created and become embedded in cultural and social structures. As a result, they form what have been

referred to as '*horizons of possibility*' where characteristics are attributed as valuable in the particular context (Scanlon et al., 2007, p228).

In establishing these arbitrary boundaries, binary oppositional discourses are frequently used to create space between the 'self' along with those one associates with, or wishes to be associated with, and others who one does not wish to be associated with, by the particular audience. In health care, the discourses of 'good' vs 'bad', 'new' vs 'old', 'evidence-based practitioner' vs 'routine based practitioner' are often used to achieve this and in the process either establish or challenge the existing hierarchy. Representing oneself to others almost always serves the speaker's objective of favourably emphasising their own image as a 'good' person (Alvesson et al., 2008). Being a 'good' person informs the claim of being a 'good' nurse and is inherently associated with the notions of care and compassion that the idealised nurse continually strives to demonstrate in order that their patients might flourish (Sellman, 2011).

Identity understood and researched as self-concept brings to the fore factors that influence what it means to be and act as a nurse (Fagermoen, 1997). These are frequently expressed as values that guide agency and emotions that ensure meaningfulness. Recent research highlights the significance of meaning for identity, a feature which appears consistent for nurses internationally (Malloy et al., 2015).

Identity as trajectories

More contemporary research has gradually begun to untangle the notions of professional self-concept from those of professional identity (Johnson et al., 2012). While the former is defined as '*our personal understanding of our perceived attributes*' (p563) the latter is understood to be '*a sense of self that is derived and perceived from the role we take on in the work that we do*' and therefore how we interact with people and artefacts in a particular context (p563). It is influenced by the work of Skorikov & Vondracek (2011) who suggest that occupational identity formation often plays a leading role in the formation of other aspects of personal identity, representing '*a major factor in the emergence of meaning and structure in individual's lives*' (p694). Increasingly professional identity is being

conceptualised as a pathway or trajectory and is dynamic (McAlpine, 2012) with a recognition that formation begins prior to any formal professional education and involves the melding of the personal and professional. Cook et al. (2003) established new nursing students had a clear sense of occupational identity, closely linked to their sense of self and based upon images and the influence of significant others even in the absence of personal experience.

Conceptions of identity as a trajectory foreground the processes of formation and reformation that continue throughout formal education and into the early career phase (Deppoliti, 2008; McAlpine et al., 2014; Newton et al., 2009). The limited consideration of identity trajectories in nursing requires a glance towards teacher education. Beijgaard et al. (2004) established in their review that identity as a trajectory represented the coming together of personal and professional sub-identities where the individual exercises agency rather than passive reaction. This action takes the form of bridge-building between existing and newly revised identities. Many nursing students, especially mature students, come from previous careers as carers or Health Care Assistants (now Nursing Assistants). There is a need to accommodate the previous sense of self alongside the values, beliefs, and practices that may conflict with the new sense of self as a student causing discomfort and a sense of culture shock (Brennan & McSherry, 2007).

The result of an extensive concept analysis by Ohlén & Segesten (1998) concluded that the professional identity of the nurse is fundamentally integrated with their personal identity, each closely influencing and informing the other. It consists of the objective image other people hold of the person in a reciprocal relationship with the subjective feelings and experiences of themselves as a nurse. This mirrors the accumulated research on teacher professional identity which recognises the complex interplay between the subjective and objective across a range of contexts and expressed in terms of the connections between the teacher, their students, and the workplace in the context of micro (personal) and macro (national) environments (Meijer et al., 2014).

A major feature of identity understood as trajectories is the centrality of continuous and multifaceted reformulations over a person's lifetime. While a great deal of interest is

already focused on registration and beyond, there is a growing appreciation that this pathway, definable or not, extends from before the commencement of and throughout nurse education (Johnson et al., 2012). Increasingly, educators responsible for professional preparation across a range of settings acknowledge the potential of professional identity development as a critical focus for their endeavours (Goldie, 2012; Johnson et al., 2012; Langendyk et al., 2015).

From a detailed review of the nursing specific literature, various conceptions of identity and professional identity have been established. These were presented in broad themes of identity as adopted societal image, the consequence of socialisation, as self-concept, and as trajectories. Images, experiences, emotions and the ongoing formulation and reformulation of identity inform the first three research questions but also come together in the next section where I consider identity constituted in discourse. Somewhat surprisingly, unlike many other professions, there is very little nursing specific literature based on this conception of identity.

Identity constituted in discourse

Many contemporary theorists conceptualise identity through discourse. It is through discussions about 'being', 'doing' and 'believing' that abstract notions are reified. Of particular relevance to this study is the work of narrative theorists who regard identity as the accumulation of stories people tell about themselves and the uses to which these are put (we tell about ourselves) (Bamberg & Georgakopoulou, 2008; Kraus, 2006; McAdams et al., 2006; McAdams, 1997; Ricoeur, 1991). The common emphasis shared by each approach is that it is through the narrative telling that identities are constructed and reconstructed. *'[S]elves are made coherent and meaningful through the narrative or 'biographical' work that they do'* (Benwell & Stokoe, 2006, p42). As a result, identities can be viewed as *'achievements'* (Lawler, 2014) or an *'accomplishment'* (Benwell & Stokoe, 2006), created as a result of the way people talk about their lives. This view does, however, risk regarding identity as an objective, or an achievable end point rather than a waypoint on a continuing process of becoming (Ybema et al., 2009).

Polkinghorne (1988) understood identity in terms of the person's life, having an inherently temporal nature as one experiences and interacts with the world and seeks to make sense of these happenings through a narrative form of knowing. As a result, Polkinghorne (1988) saw identity not as an entity that grows and develops reaching a fixed point, but as a constantly evolving sense of self. According to Ricoeur's (1992) conception, narrative identity is fragile and incomplete, forming part of the overall process of narration. The narrative creates a bond between the past, the present and the future with the creation of an identity that is both temporal and contextual. It also seeks to address the paradox of similarity and difference. Ricoeur (1992) suggests that identity is a combination of selfhood (*memete*) and similarity (*ipseite*), the former being the way in which a person defines herself or himself as distinct from others and the latter being the endurance of this individuality over time and in the presence of similarity.

McAdams & McLean (2013) regard narrative identity as the construction and internalisation of '*an evolving and integrative story **for** life*' [my emphasis] in order to achieve '*some degree of unity, purpose and meaning*' (p233). The self is configured through the recall, interpretation and reinterpretation of episodes from the past, real and imagined, that are used to comprehend the present and anticipate the future. They are produced and performed for ourselves and others on a continuing basis. Examples from nursing (Chan & Schwind, 2006) and education (Young & Erickson, 2011) illustrate the potential of the self-study of narratives as a means of illuminating understating of personal and professional identities. Both studies are grounded in the close examination of life experiences, the ways in which these have been storied, told and retold. For these researcher/practitioners, it provided a mechanism of self-analysis. For others, the analysis of narratives provides a means of making sense of significant change resulting from trauma (Lambrou, 2014; Loots et al., 2013), illness (Mills, 1997) and bereavement (Campesino, 2007). Stories, particularly self-narratives, offer a mechanism by which diverse, complex, and sometimes contradictory interpretations of experiences can be drawn together into a coherent account of the self (Maple et al., 2007; Minichiello & Kottler, 2009).

The stories we tell do not simply represent accounts of the experiences. They are influenced by the teller's memory, the cultural and social structures of story-telling as well as the

preferences we wish to perform for the particular audience in the particular context (Riessman, 2001). As a consequence, where the audience is a researcher with a particular interest in a person's stories, it is essential that they recognise the co-construction of the narrative and, during interpretation, are open to the details of the narrator's position and situation (Frid et al., 2000).

The audience for a projected or presented identity is critical, influencing the extent to which people exert their claims. Projected identities in the form of statements and actions are generally understood to represent not only how a person sees themselves but also how they wish to be seen by others (Barreto et al., 2003). Drawing on the Bakhtinian notion of 'dialogism', that language mediates human perception, this performance in response to the social context becomes a process of 'self-authoring'. Humans are constantly being addressed by and answering to the world around them, choosing responses that enable them to present a persona. *'We create our identities by telling the stories of our lives'* (Dornan et al., 2015, p176). The degree to which this is challenged or reinforced by observers is likely to dictate the extent to which people internalize these self-conceptions and repeat or embellish them in similar contexts (Ibarra & Barbulescu, 2010). In accepting that identities are socially constructed and therefore inherently dependent upon and called into existence in light of the context, identity becomes a claim one makes in order to achieve a position and acceptance, *telling oneself into nursing* (Jordal & Heggen, 2015). From a postmodernist perspective, it is only durable to the extent that the person is able to continue making the claim rather than any inherent aspect of the person. Ybema et al. (2009) suggest that identity is *'a matter of claims, not characteristics; persona not personality; and presentation, not self'* (p306).

Discursive approaches have come to play an increasingly dominant role in the understanding of identity construction and articulation where language is no longer understood simply to *convey* meaning but to *make* meaning. Talk, be it formal or casual, as well as created texts are generally understood to be the primary expressions of identity and therefore the focus of much research (Ybema et al., 2009). Other forms of non-linguistic communication are increasingly being used acknowledging the multidimensional nature and significance of identity representations (Riessman, 2008a). These might include the use of

artefacts, tools, policies and dress codes as means of embodying the representation and offer an essential additional and enhanced perspective on identity talk. People engage in discourse at multiple levels as a means of comprehending and meaning making in order to achieve some degree of coherence in their daily experiences. The language one uses represents and facilitates the socialisation processes of entry into a given collective and culture. It informs the way rules and routines are internalised and represents a mechanism for self-definition and re-presentation as part of the community.

The consequence of a dynamic, continuous and reflexive notion of identity is that it takes on multiple and simultaneous features. Identity is both what is projected by the individual and what is perceived by the audience(s). Crucially, this audience is composed of the performer themselves, here beginning nursing students, as they engage in the act of improvisation and reformance, the re-performance of familiar scripts in novel ways that bring about new possibilities (Walter, 2003) . The space where these meet creates a venue for dialogue and self-authoring (Bakhtin, 1981) as well as an opportunity /invitation for interpretation. As a result, identity might be conceived as an emergent co-construction in a temporal and contextual space, *'fabricated' through discourse, 'staged' through performance and 'fictionalized' through text'* (Ybema et al., 2009, p305). Identity is the situated outcome of the selections made by persons from socially constituted repertoires and resources that they then portray to others in the form of identity claims (Bauman, 2000). Rather than fixed assertions about the person made either by themselves or listeners, identity claims are understood here to be hypothetical, notional statements about how the person positions themselves to themselves and others. They are speech acts that achieve reification in the act of telling. As such they are semiotic resources that form critical elements of what Sfard & Prusak (2005) term an individual's 'first-person identity', statements within stories intended to establish who the person is in a given context.

This review highlights how notions of identity are problematic resulting from a distinct lack of agreement about the meaning of the term (Smith & Sparkes, 2008). Professional identity in nursing is often presented as *'monolithic, unchanging and stable'*, and once achieved, forms the basis for a person's professional career (Miró-Bonet et al., 2014, p769). Hurley (2009) suggests that these conceptions of nurse identity are rather simplistic and do not

reflect the true complexity of identity. Notions of stability, continuity and unity are increasingly being challenged by post-structural and feminist philosophy that recognises social fluidity. Research activities are increasingly addressing the social, fragmented and multiple natures of identity and the capacity of the individual to act and reposition themselves in response to prevailing circumstances. In a recent review of student teacher identity, Rodgers & Scott (2008) identified four basic assumptions underpinning contemporary notions of identity that will inform this research at a theoretical and methodological level. Identity is formed in (1) multiple contexts, dependent upon cultural and historical forces and (2) in relationships with others. As a consequence, they are (3) *'shifting, unstable and multiple'* and (4) *'involves the construction and reconstruction of meaning through stories over time'* (p733).

Poststructuralist orientation

Having reviewed the usage of identity within the nursing literature, I now seek to outline the philosophical standpoint that will inform this inquiry into nursing students' first steps to becoming. I will begin by outlining the poststructuralist perspective and the underpinning assumptions before continuing to address the notion of becoming.

Post-structural views of identity build on the work of the French philosophers including Foucault and Deleuze. A post-structural perspective rejects the conceptualisation of identity as a stable product of the self, represented as traits or personal characteristics and so is highly relevant in this research context. Similarly, they reject the alternative notion that identity is a social phenomenon and the result of processes of socialisation, role modelling and group identification, sometimes through the emulation of these traits (Bleakley, 2011a). As a result, post-structural theorists discount the notion of a unified identity in a world that is understood, not in absolute and universal terms but, in relation to the ever-changing time and context. Rather, they consider the self to be constituted, not solely on the basis of experience but on the basis of the discourse of experiences and the resultant emotions (Zembylas, 2003). This perspective highlights two critically important assumptions that have significance for both the focus and process of this research inquiry.

The first is the agency of the individual which is understood to have prominence. In many conventional studies of identity, the individual might be regarded as a ship subjected to the force of multiple and changeable winds. Action might be characterised as a reaction to the prevailing circumstances. The task of the researcher is to establish the causal relationship that places the ship at particular points with an objective of 'knowing' the singular process of how a harbour is reached. For the post-structuralist, the individual, who embodies diversity in their actions and associations, is regarded as active and in possession of valid, multiple and contrasting views of themselves that the researcher seeks to understand (Cohen et al., 2011). A poststructuralist perspective creates opportunities for individuals to exercise their agency through acts of power and resistance that influence the way they view themselves. These views of self are the consequence of discursive practices in historical contexts, are multi-layered and changeable.

This introduces the second assumption, that of dynamism. The post-structuralist view of identity acknowledges the constant shifting, formation, and reformation that results from minor micro context changes in the local and unique, through to major societal and cultural shifts over time (Zembylas, 2003). As a consequence, identity is understood to be the interplay between multiple and competing discourses and therefore is both temporary and situated. It is the combination of individual agency and dynamism that makes the post-structuralist view of identity construction future orientated and potentially transformational (Biehl & Locke, 2010; Bleakley, 2011).

Becoming

With a few notable exceptions (Bleakley, 2011; Sandvik et al., 2015) in the majority of reviewed texts that use the term becoming, it serves to represent a process, the significance of which is the end point of being. '*Becoming a nurse/professional*' is used to acknowledge some of the stages or processes that are critical to the state of '*being a nurse/professional*' (Clouder, 2003; Halperin & Mashiach-Eizenberg, 2014; Holland, 1999; Ronfeldt & Grossman, 2008) but often place emphasis on the destination rather than the journey. Even in circumstances where the complexity of the journey is foregrounded, authors rarely are explicit about their philosophical orientation (Davey & Bredemeyer, 2011). Where becoming

a professional or transitioning is reduced to the acquisition of a set of traits and knowledge, the '*process of becoming*' represents a series of stages of being on a path with a definitive end point. Becoming as a metaphor for professional learning, however, emphasises the continual and iterative growth of the whole person in the making and might be considered '*the heart of the matter in [nurse] education*' (Pratt & Back, 2013; Sandvik et al., 2015, p70). Becoming enables (me) the researcher to dispense with the simplistic notions of transition as linear, staged, cumulative and uni-directional (Worth, 2009), to embrace the complexity and fluidity of how people come to perform in academic and clinical settings over time (Bauman, 2007).

The challenging philosophical work of Deleuze rejects completely the notion and value of 'being' in favour of the continually dynamic notion of 'becoming' which takes on a very specific form. For Deleuze becoming has no origin or endpoint. It is creation. Being is regarded as a stable moment in the constantly changing flow of becoming that totally subsumes and enfolds the individual (Colebrook, 2002). '*Becoming is a verb with a consistency all its own; it does not reduce to, or lead back to, 'appearing', 'being', 'equalling' or 'producing'*' (Deleuze & Guattari, 2004). Understanding identity from the Deleuzian perspective is challenging especially when presented as notions of personal, academic and professional identity. This artificial separation might be interpreted as aspects of the self that, while dynamic and inter-related can be arbitrarily bounded. Applying post-structural theory to the development of medical professionals, Bleakley (2011) suggests '*becoming can be seen as a series of identity positions held in network or assemblage*' (p133). As such, becoming refers to the formation and transformation of professional identity and has significant potential in improving our understanding in the context of nurse education (Sandvik et al., 2015).

An 'assemblage' refers to the connections among a number of objects that draw it into a single context that goes beyond the simple description to include a potential for creation. Assemblages lack organisation in a formal sense and can draw in disparate elements, the consequence of which is that they are capable of producing various effects and not simply a single dominant outcome. The authors use the example of a book containing words, meanings, messages that are brought into existence through its relationship and

connections with what is around it. In relation to identity, Bleakley (2011) interprets assemblages as networks of inter-related *'forces in time and space that crisscross at points'* (p134). Work experiences or clinical placements might be considered in terms of assemblages that provide temporarily held identity positions and emotional consequences which provide meaning to experiences. These emotions have been postulated to act as the 'glue of identity', establishing a connection between the thoughts, judgments and beliefs that associate meaning with experience (Haviland-Jones & Kahlbaugh, 2008). Emotions are a critical resource in the crafting of identity. Zembylas (2003) argues that a post-structural consideration of identities must analyse the emotions in which they are grounded and advocates a narrative approach as an appropriate mechanism for achieving this.

Figuring and Figured Worlds

Figured Worlds theory draws on foundational elements from the work of Bourdieu, Vygotsky, and Bakhtin. As *'realms of interpretation'* (Holland et al., 1998, p51) they are a space where people make and modify meanings associated with the material and conceptual artefacts that surround them (Vygotsky, 1986). They exist as frameworks of cultural, social and historical forces, constructed of common practices, interactions and local discourses (Holland et al., 1998; Rubin, 2007). They are formed and reformed by the often 'taken-for-granted' sequence of events that act as reference points and become cultural artefacts. These are given meaning by their presence within a particular Figured World and act as tools, both practically and psychologically, to bring the world into existence (Ma & Singer-Gabella, 2011). Figured Worlds pre-exist participants who inherit the artefacts, discourses, and practices that influence their notions of self. *'Neophytes are recruited into and gain perspective on such practices and come to identify themselves as actors of more or less influence, more or less privilege, and more or less power in these worlds'* (Holland et al., 1998, p60). It is a theory that has considerable potential to illuminate the ways beginning nursing students develop their identities in novel and challenging situations.

In these situations, people 'figure out' who they are by reconceptualising and shifting their self-understanding particularly in relation to others. Through the act of figuring people come to understand themselves and the *'ability to craft their future participation'* (Urrieta,

2007, p120). The development of emerging identities or the process of becoming is often achieved through adjustments to existing identities as the person re-authors herself or himself. Narratives, as used by the participants in this inquiry, form a potent mechanism for achieving this transformation and exercising agency. They also provide a valuable and insightful conduit for the identity researcher. These *'figurative'* or *'narrativized'* identities offer a means of improvising new identities and challenging positional identities that act to constrain and represent power, hierarchy and social affiliation (Holland et al, 1998; Timmis et al, 2015).

Placing the notion of figuring alongside the dynamic process of identification and becoming (Holland et al., 1998) emphasises the agency embodied and enacted by the individual. Figuring, rarely defined within the texts, is, therefore, the act of giving shape and form to, or imaging and thinking about the identity or self-understanding of the person. As they take the first steps on their professional journey, beginning nursing students are figuring and becoming through their participation in multiple communities.

Figured Worlds have been described as a 'contextual identity theory' that seeks to expose for analysis the constructs that form the basis of identity development, more so than many other socio-cultural identity theories (Dornan et al., 2015). Its particular strength lies in its appreciation of the simultaneous development that takes place at the point of intersection between multiple Figured Worlds to which individuals belong (Peña-Talamantes, 2013). Various education environments have been considered as Figured Worlds including schools (Caraballo, 2012), prisons (Urrieta et al, 2011), libraries (Morgan, 2008), colleges (Peña-Talamantes, 2013) and universities (Timmis et al., 2015) as well as disciplinary learning contexts such as medicine (Bennett et al., 2016) and engineering (Tonso, 2006). To date, there has been no application to nurse education.

Figured Worlds and positionality (positional identity) form the first two of four identity contexts. The third is a space of authoring which draws heavily on the Bakhtinian notions of dialogism and refers to the ability of individuals to make meaning from their social experiences through the authoring of responses as internal dialogues or as actions and performances. Personal agency is expressed through the requirement to continually answer

that which surrounds the individual and '*write oneself into the world*' (Peña-Talamantes, 2013, p270). In doing this, the individual engages in the final identity context, that of world making. This involves the constitution of new Figured Worlds in which there is potential to create new discourses, artefacts and identities. Where pre-existing Figured Worlds conflict, the individual is required to negotiate and renegotiate their identity. From this theoretical position, identity formation and re-formation is a continuous unending process, not of a singular entity but a '*unique, contextually defined*' self-definition of which it is possible to glimpse critical moments (Kram et al., 2012, p305). It therefore provides an appropriate but underused theoretical framework for investigating the emerging identities of beginning nursing students.

Conclusion

This chapter has provided a summary of the various interpretations of *identity* employed within the nursing literature. Identity as a societal image emphasises the effect of cultural artefacts while socialisation focuses on the processes of association and affiliation. Identity as self-concept attends to values and emotions while identity trajectories foreground notions of agency, the effect of multiple contexts and the open-ended nature of development. Each interpretation offers a particular facet of understanding. Unlike many other professions, there is something of a dearth of research that explores, in detail, the genesis of nursing identities constituted in discourse, the interpretation used in this study. Figured Worlds provides a theoretical framework within which the development of identity can be investigated. It is able to accommodate a notion of identity understood to be a temporary product of the meaning made of past and present experiences, the cultural context within which this display is conducted, and the audience of the performance. In this chapter I have sought to justify my adoption of a post-structuralist approach to identity, a standpoint that aligns ontologically with particular methods of investigation. In the next chapter, I will articulate the methodological approach consistent with this philosophical position as well as offering a justification for the design choices made.

Chapter 3 - Methodology

Introduction

The previous chapter presented and discussed a range of theoretical conceptualisations of identity, the ways these have been conceived in nursing and the significance of a more detailed understanding of this process for those with an interest in nurse education. I have also outlined the theoretical developments and philosophical shifts, which have informed the methodological approaches used in identity research to date. In doing so I have established the view of identity that informs this research.

This chapter sets out both to explain and justify the methodology and methods employed in this study. The aim is to illustrate the design choices as well as present a detailed description of the practical steps that were undertaken in the implementation of the study that sought to answer the following questions.

1. What do beginning nursing students narrate as significant experiences, events, and interactions during the first year of a pre-registration undergraduate programme?
2. What are the forms and functions of stories told by beginning nursing students as they develop their emerging identities?
3. What are the identity claims that beginning nursing students make? How do these change as they progress through their first year of a pre-registration undergraduate programme?
4. What are the Figured Worlds beginning nursing students inhabit?
5. How do beginning nurses go about figuring their identities in these worlds?

I will provide a clear exploration of the nature of the narrative approach used here in order to emphasise the alignment between my ontological and epistemological standpoint, the focus of the research and the practical procedure employed. It is intended that the reader appreciates the learning context of the participants as beginning nursing students, the location for the study and the nature of the research relationship.

Each of the data collection methods is discussed with an inclusion of the relevant practical and theoretical considerations. Since many of these raise issues of an ethical nature, I have provided an account of the ways in which issues of anonymity, confidentiality and consent have been addressed as well as broader considerations of insiderness and authentic representation.

In the final section, I offer an account of the systematic multi-level analysis adopted in order to achieve a detailed engagement with the data. It is a specific intention that this illustrates the iterative nature of the analysis and the process of conceptualising and formulating the analytical framework. This, in turn, informs the aspects employed to evaluate the quality of the interpretations and the representation in later sections of this thesis.

Social constructivism

In the course of early deliberations about how best to address my research interests, I sought to clarify my position concerning how I view and think about the social world. The assumptions that underpin social constructivism are consistent with the basis of my clinical, educational and consequently, research practice. Rather than reality and knowledge being *a priori*, social constructivism legitimises the interpretation and construction of subjective meanings of experience through the interactions a person has with their worlds (Creswell, 2007). Individuals have the capacity and agency to interpret the world around them. These interpretations are multiple and various, influenced by characteristics of the prevailing social and historical context (Corbin & Strauss, 2008).

Social constructivist relativist ontology and subjectivist epistemology are consistent with my beliefs that people have a legitimate view of the world based on their own experience. Each person, be they patient, student or research participant forms a unique representation of the world. There is an unlimited number of alternative views of reality and these are socially negotiated. Not only does this approach value the person, it also values their interpretation and the way it is represented.

Various research methodologies are consistent with this philosophical standpoint. During the research design phase, I appraised, but ultimately rejected, discourse analysis, an ethnographic case study approach, and interpretive phenomenological analysis in favour of a narrative inquiry approach.

Narrative Inquiry

Narrative inquiry offers an approach, drawing on a postmodernist and social constructivist worldview, which recognises and values multiple voices or truths and seeks to understand the meaning of experience through the use of stories as data (Bleakley, 2005). Crucially the epistemological function is to explain and understand the worlds of people and the meanings of their experiences rather than attempting to establish decontextualized truths (Joyce, 2015; Wang & Geale, 2015). It employs methods that reflect person-centred values, placing the participant at the centre of the research process, and have significant utility for practice-orientated professions such as education, nursing, and nurse education (Green, 2013).

The growth of narrative approaches to research has occurred in parallel with, and therefore been influenced by, diverse fields including literary theory, anthropology, and psychology. Contemporary narrative inquiry sits at the intersection between humanist and poststructuralist traditions (Squire et al., 2013) and seeks to offer a fundamental means of understanding and thinking about experience (Connelly & Clandinin, 2006). Webster & Mertova (2007) refer to Narrative Inquiry as a research method, but Clandinin et al. (2007) argue that it is more than simply a way of collecting and managing data. Recognising the overlapping characteristics of much qualitative research, the emphasis on sociality shared with ethnography and the use of stories shared with phenomenology, they argue that narrative research has distinctive qualities which create a delineated, if not unique, analytical space for the consideration of meaning making (Hendry, 2007). These '*commonplaces*' are understood to be the interrelated components of a complex system that form the basic structure for analysis. The personal social conditions of experience (sociality), the location in a temporal space with influence on past, present and future as well as changing location or place combine to create a three-dimensional inquiry space

(Clandinin et al, 2007) that frames narrative research irrespective of the theoretical eclecticism that characterises the field (Andrews et al., 2011; Squire et al., 2013).

The last decade has seen a significant increase in the use and general acceptance of narrative-based research (Chase, 2011; Squire et al., 2014). Early pioneering work advocating the narrative form of knowing and the ways this is used to construct reality (Bruner, 1986, 1990, 1996; Polkinghorne, 1988) served to encourage and embolden practitioner researchers in the fields of education, psychology, and health. Narrative approaches to inquiry place the human being, their life experiences and their interpretation of these experiences at the centre of the research process (Connelly & Clandinin, 2006). It seeks to understand the real-life experiences of people through their stories, sometimes silenced or unheard by other inquiry methods, and offers a mechanism for disseminating these in a universally familiar format to a wider audience (Wang & Geale, 2015). *'The approach is well suited to study subjectivity and identity largely because of the importance given to imagination and the human involvement in constructing a story'* (Mitchell & Egudo, 2003, p2). These fundamental principles have both a personal and a professional appeal since they mirror my own approach to nursing and education practice as well as providing a coherent approach towards extending conceptions of the figuring of identities among beginning nursing students.

The epistemological assumption that underpins all narrative inquiries is that human beings make sense of variegated experiences by applying a story structure (Bignold & Su, 2012). Individuals seek to interpret, organise and understand their daily lives by telling themselves and others the story of events and experiences (Connelly & Clandinin, 2006). These stories allow people to manage and make sense of the past, prepare for the future and guide in the present (Reid & West, 2015). In this research, each participant was able to recall and recount a number of occurrences, evaluations, and opinions that provided an insight into the mechanisms by which they made sense of their identities, their worlds and their place within them.

The function of narratives

As a resource of interaction and communication, narratives, in various forms, may serve to persuade or mislead, entertain and engage, encourage a sense of belonging and motivate action (Riessman, 2008b). Some have theorised that all stories stem from seven basic plotlines (overcoming the monster; rags to riches; the quest; voyage and return; comedy; tragedy; rebirth) but, it is their telling that reveals the uniqueness and idiosyncratic function (Booker, 2004). They provide a structure for experience and means by which reality can be constructed (Bruner, 1990). As a verbalised form of mental representation they simultaneously enable retrospective consideration of past events and the prospective formulations of the individual mindful of their audience (Herman, 2009; Monrouxe, 2009b). Occupational stories are told to convey the collective and cultural values of a group, affirming or establishing membership and locating the present in the historical and future context (Cortazzi, 2001). Many contemporary narrative theorists view narratives as a means by which identity is fabricated underscored by Yuval-Davis's (2006) claim that '*Identities are narratives, stories people tell themselves and others about who they are (and who they are not)*' (p202). While various interpretations of narrative view it as textual accounts, as a communicative process or as a social phenomenon integrating experiences and identity formation (De Fina & Georgakopoulou, 2011) it is this latter view that I have adopted in this research. In order to achieve this focus on the identity work of narratives, it was important to consider both the *what* (content) of the story as well as the *how* (performance) of storytelling as people construct their sense of self in and across a variety of settings and times (Chase, 2005). When challenged to cope with major changes in life, including trauma (Etherington, 2008), illness (Frank, 2013), and displacement (Gomez-Estern & de la Mata Benitez, 2013) people often turn to stories to achieve meaning. Generating '*key narratives*', often told, polished accounts of experience, serve as artefacts and markers of identity to which people can return and re-perform in order to establish personal and cultural connections (Boenisch-Brednich, 2002; Jordal & Heggen, 2015).

In this research narratives and stories are understood to represent, at the same time, the retrospective consideration of past events and the prospective formulations of the individual who is mindful of the audience (Monrouxe, 2009a). As a result, they represent a

preferred or 'spun' story which demands reflexivity on the part of the researcher seeking to use a narrative inquiry approach (Patterson, 2013; Trahar, 2009).

Research procedure

In order to answer the research questions stated earlier, this study applied a narrative inquiry approach in order to elicit and analyse the stories participants told of their initial experiences as beginning nursing students. Stories were told in the context of what might typically be called semi-structured interviews at three points over the course of the first 10 months of the participant's pre-registration programme. In addition, some participants provided audio diary entries recorded periodically throughout this time. All participants also gave me their permission to access the personal statement submitted as part of their university application process and which represented a form of storied data generated prior to their formal beginning of the nurse education programme.

Location and context

The location was the satellite campus of a well-established UK university. Pre-registration Adult Nursing programmes have been run at Diploma, Bachelors and Masters level variously over the past 25 years following the movement of nurse preparation into the Higher Education sector. The satellite campus has grown over the course of 15 years with a total student population of approximately 350 students. It is located in the main urban centre of a largely rural county in Southern England. Students were expected to complete their practice experience in primary and secondary health care settings throughout the county.

Representing those involved

Those who contribute to research are often conceived in ways that promote the interests of the researcher. From *subjects* to *respondents* to *participants*, the assumptions underpinning the relationship will influence not only the design and conduct of an inquiry but also the analysis and outcomes of a research endeavour. My use of the term participant seeks to convey their active rather than passive role in data gathering. More accurately they were storytellers. I was their audience and ultimately the co-constructor of what they told.

Participants

The study was introduced to approximately 90 students in the first week following their enrolment and induction. An information letter outlining the research project and participant obligations was made available to any interested individuals. The use of a purposive, self-selected sample was consistent with the aims and the methodological standpoint of the study. The criteria for becoming involved was simply a willingness to share (with the researcher only) the experiences of beginning their professional nurse preparation. This was to represent '*exemplars of the experience for study*' (Polkinghorne, 2005, p140) as potential '*collaborators*' in answering the research question(s) (Moen, 2006, p61).

Of the 17 people who expressed initial interest, 12 attended the first one-to-one meetings. Over the course of the 10-month data gathering period, seven participants discontinued their involvement with the research. Four chose not to attend the second round of meetings and three others were unable to attend the third round. This meant five participants were interviewed at three points in the year and these individuals formed the study population.

All five participants are women, four of whom are in their thirties or forties, had children and were looking to either change careers or realise a long-held ambition. Two were graduates and another one had significant prior experience in care work. One participant was in her early 20s, having completed a vocational qualification at a Further Education College.

The demographic details of the five participants illustrates that they are not representative of the 'traditional' nursing student but do represent an increasing diversity among nursing student cohorts (Jeffreys, 2012). The *traditional* nursing student in the UK has previously been identified as a female pre-registration undergraduate who is under 25 years old and completed further education (A-level or Access to Higher Education). Non-traditional students are defined as those for whom any of the following categories might apply.

- 25 years old and over,
- commute rather than live where they study,

- have children,
- come from a minority ethnic or racial background,
- are male,
- have English as a second language,
- are financially independent,
- work full-time,
- attend university part-time,
- are switching careers,
- or are seeking a second degree.

As indicated above, the group of participants who contributed to this study were self-selecting. Potential participants needed a general interest in the topic and have time to contribute. Most importantly, they also had a degree of confidence in their own ability to tell stories, either about experiences from their past or that they anticipated in their future and a belief that these were of interest.

Retaining participants

Maintaining a regular and appropriate level of communication with all participants was necessary throughout the 10-month data gathering period. After the initial meeting (described below), each participant was periodically sent a reminder e-mail restating the broad focus of the study and encouraging them to record audio diary entries. Each diary entry received was promptly followed up with an acknowledgement confirming receipt and thanking the person for their contribution. The tone of these communications was deliberately constructed to encourage a sense of partnership and commitment without being burdensome or demanding.

Invitations to each round of meetings were sent by e-mail. Non-responses were followed up with a second e-mail and following this, the participant was considered to have withdrawn.

Data Sources

Meetings

The principal source of data was the stories participants told during one-to-one meetings. Participants were invited to meet with me on three separate occasions. The initial meetings were conducted between Weeks 3 and 6 of the first semester (Oct 2014). This was prior to the start of introductory clinical placements (See Table 1). The second meetings occurred in the second semester (Feb 2015) following the participant's introductory clinical placement and on completion of three introductory modules. The final meetings happened in May or July 2015. This was towards the end of the first academic year when participants had completed their second clinical placement and a further three academic modules.

	<i>Programme activities</i>	<i>Research activities / Data gathering</i>
Week 0	Induction Week	
Week 1	Semester 1(Introductory) modules delivered	Research project introduced
Week 2		Negotiate interview appointments
Week 3-6		First interviews (12)
Week 7		Audio diaries
Weeks 8-13	Introductory clinical placement (Part 1)	
Weeks 14-15	Christmas vacation	
Weeks 16-17	Introductory clinical placement (Part 2)	
Week 18-19	Semester 2 modules delivered	Second interviews (8)
Weeks 20-22		
Week 23		Audio diaries
Weeks 24-27	Second clinical placement (Part 1)	
Weeks 28-29	Easter vacation	

Continued

Weeks 30-33	Semester 2 modules delivered	Audio diaries	Personal statements
Weeks 34-35	Self-directed study	Third interviews (3)	
Weeks 36-42	Second clinical placement (Part 2)	Audio diaries	
Week 43	Mandatory training	Rescheduled Third interviews (2)	
Week 44-50	Summer vacation	Data collection ended	

Table 1: Timeline to indicate the structure of the first year programme and the timing of data gathering points

All of the meetings took place in a ground floor room in the university building away from the main teaching, library, and staff offices. It was intended to be convenient for the participants and provide a discreet but secure environment. The meetings took place with the corner of a table positioned between myself and participants. A small digital voice recorder and a secondary tablet voice recorder were used to unobtrusively capture the dialogue and mitigate the risks of technical failure and data loss.

Each of the first round meetings (12) lasted approximately one hour. They were used to confirm permission and complete consent forms, introduce the research project, establish the research relationship and gather initial data. Participants were asked to briefly outline the story of how they came to be a student on the course and explore the factors that influenced their decision to embark on a Nursing degree programme.

Eight meetings were conducted in the second round and five in the third round. Each of these lasted for between 35 and 70 minutes. At the start, I took the opportunity to restate the focus of the study and re-establish a rapport with the participant. I felt this action was important in establishing my role in this context as interested inquirer rather than course tutor, both for me and the participants.

The narrative inquiry 'interview', which might be characterised simply as '*listening to people's stories*', requires skill and effort to plan and conduct. The aim of the interview was to provide participants with space to improvise a story drawing on the recollections of their

choice. Rather than make use of a previously constructed schedule, I sought to engage the participants in a conversation initiated by an open invitation to recall the nature of learning experiences. During the meeting, I tried deliberately to avoid requests for explanations or statements of attitude and opinion (Jovchelivitch & Bauer, 2000). I was mindful of Riessman's (2008a) suggestion that *'the specific wording of a question is less important than the interviewer's emotional attentiveness and engagement and the degree of reciprocity in the conversation'* (p 24). In order to achieve this, I sought to *listen* and resist the temptation to simultaneously ask and analyse. Ceding control was uncomfortable but essential in creating the atmosphere for storytelling.

Field notes

Field notes were recorded immediately after the meetings. These provided an opportunity to record my responses to the context and the information that had been shared by participants. In order to actively listen to the participants, I did not make notes during the interview.

Many participants attended between classes, before or after clinical skills sessions and some came to the campus specifically for the meeting. In some instances, they made direct reference to the activities that had just undertaken and it was important to record these details as context for some of the story.

On a number of occasions, the end of the recording triggered further disclosures that elaborated on points raised during the meeting. Where these were substantive, I sought the participant's permission to make notes on the conversation and include this as part of the data.

Audio diaries

In an attempt to capture stories opportunistically, participants were asked to make audio diary recordings periodically throughout the study period. At the end of the first interview, each person was given a small USB digital voice recorder. They were asked to respond to the request *'Please tell me a story about the people or events that have happened to you since*

your last diary entry and how it has affected the way you see yourself as a student, a nurse, and a person.' Recording could be as frequently and for as long as they wished. Along with the recorder, each participant was given an instruction sheet (See Appendix 3) detailing how to use the device, password protect the file and send to a dedicated e-mail address.

Two of the participants made regular use of this in the early phases of the study, recording material between 3 and 6 minutes in length. In the latter phases fewer diary entries were recorded. Some participants offered their written reflective accounts, however, these were not included in the data set (See Table 2).

<i>Participant pseudonym</i>	<i>Application Personal Statement</i>	<i>Meeting 1 (Oct)</i>	<i>Audio diaries (Oct-Dec)</i>	<i>Meeting 2 (Feb)</i>	<i>Audio diaries (Feb-May)</i>	<i>Meeting 3 (May/Jun)</i>
Andrea	✓	✓	✓✓✓	✓		✓
Beth	✓	✓	✓	✓		✓
Denise	✓	✓	✓	✓	✓✓	✓
Helen	✓	✓		✓		✓
Julia	✓	✓		✓		✓

Table 2: Data gathered from each participant at points throughout the study

The audio diaries were used to provide rich, contemporaneous accounts of experiences and the potential for access to the emotional and embodied realm that may not be available utilising other data collection methods (Kenten, 2010; Morrison, 2012). It was intended that they would provide participants with a vehicle for storytelling as well as create a space for self-reflection and a mechanism for capturing a moment that informs identities in the context of an ongoing life history (Monrouxe, 2009a, 2009b). While the audio diaries did not yield the volume of data anticipated, they were an important tool in maintaining a link between myself and the research participants over the life of the study (Williamson et al, 2015).

Personal statements

As part of the admissions process for UK BSc and MSc nursing courses, each participant is required to submit a personal statement to support their application. For this inquiry, these statements were regarded as a particular form of story designed to represent the individual in a way that results in a particular outcome, namely the offer of a place. Personal statements provide a means of exploring the identities of the applicant (Shuker, 2014) and offer a currently underutilised form of data generated at an important point in the early stages of the beginning nurses journey.

While in many instances the participants will have created these statements themselves, it is important to acknowledge that they may be the result of collaboration with family members, Careers tutors or fellow applicants past and present. Personal statements of up to 4,000 words were submitted electronically and required applicants to indicate concisely their reasons for choosing a pre-registration nursing programme as well as provide relevant supporting details. Like any of the stories told during interviews, they are representations of the person in a context; artefacts that provide a valuable additional insight when placed alongside other data.

Ethical considerations

When sharing personal stories, participants expose not only details of their lived experience but also elements of their intimate selves (Mahoney, 2007; Maple et al., 2007). Mindful of this, I proactively engaged with the University Research Ethics process as an opportunity, and obtained ethical approval (See Appendix 4), not simply to overcome a practical hurdle, but to develop and embody an '*ethical attitude*'. This is described as '*a stance that involves thinking through[ethical] matters and deciding how best to honor and protect those who participate in one's studies while still maintaining standards for responsible scholarship*' (Josselson, 2007, p538). I agree with, and have sought to employ in my research activity, Gordon & Patterson's (2013) assertion that all decisions should be guided by explicit ethical positioning.

The participant's right to remain anonymous within the research is not only a fundamental principle underpinning codes of research ethics but also contributes significantly to the covenant I wished to establish between myself and those who agreed to participate. Without trust, participants would not share their stories and much qualitative research would be impossible (Josselson, 2007). Anonymity was achieved through the use of pseudonyms employed for all participants and any other information that was identifiable such as people (patients, staff, mentors, friends, and family), place names (wards, clinical areas, placements) and organisations (health and education institutions, businesses, employers). Many participants self-censored, conscious of the professional requirement for confidentiality. Where necessary, pseudonyms were applied to interview and diary entries during transcription.

'Renaming' participants had the potential to diminish their voice by cloaking their stories and yet there was a responsibility to respect and protect all involved. In order to resolve this, following completion of the data analysis, all of the transcripts were returned to the participants giving them an opportunity to comment on the stories they had told during the previous year and the option to choose and change their own pseudonym. None of them requested a change and so the names Andrea, Beth, Denise, Helen and Julia are used throughout.

Insider research

This research was conducted at the university where I currently teach on the Adult Nursing degree programme and am also a Doctoral student with the School of Education. While this position does not represent the typical notion of the insider researcher at the start (Floyd & Arthur, 2012) the nature of the inquiry design, like all longitudinal narrative studies, increasingly approaches this standpoint (Mahoney, 2007). These two roles demanded that in order to embody the 'ethical attitude' I needed to anticipate and take active steps to avoid, negate or minimise risks of participant's name becoming known through my study. The guiding principle employed concerned avoiding any misuse of power within the research relationship.

The research was conducted on a campus where I had no teaching or assessment responsibilities. Every participant was reassured that I would take active steps to avoid any involvement with them regarding teaching and assessment at any future point in their programme. This created significant professional space between myself as a tutor and the research participants, without compromising the developing relationship as research collaborators. Listening and attending to the unique stories of others did, however, result in a vicarious experience for me as a researcher shifting my role to something more akin to the insider and demanding an essential reflexive standpoint to be adopted (Connolly & Reilly, 2007; Maple & Edwards, 2009).

Data Analysis

Pluralism and decision-making in data analysis

Unlike some other forms of social research with established traditions, narrative inquiries frequently draw on a diverse range of analytical tools and methods, many of which are adaptations or constructions designed to achieve the objectives of a particular project (Robert & Shenhav, 2014). Frank (2010) stresses that there are no universally applicable ‘*recipes*’ to identify and interpret narratives as different questions demand different approaches (Lai, 2010). Even in the published literature, clear practical accounts of how to conduct narrative data analysis are ‘*rare*’ (Squire et al., 2013). It has therefore been necessary to engage in an iterative and reflexive process that resulted in a systematic multi-level analysis.

Data preparation

A transcription convention was devised that captured sufficient detail without resulting in an unmanageable quantity of information. To this end, the information was transcribed ensuring that as well as vocabulary and grammar, performative features including pauses, non-lexical expressions, and accentuations involved in the representation of the story were retained (See Appendix 5). This was applied to the contributions made by both the participant and myself in order to honestly represent the interactive and co-constructive nature of the meetings.

The length of each transcript ranged from 4,600 to 8,600 words resulting in a total of approximately 140,000 words of data from the three rounds of interviews. The recordings of each interview and the resulting transcriptions were reviewed on a number of occasions in order to achieve familiarity and later a deeper immersion in the stories the participants told.

Early analysis

Establishing the process of narrative data analysis involved an evolution rather than the application of a set of techniques whose effectiveness could be anticipated and therefore identified in advance. While much preparatory effort went into investigating and evaluating various analytical approaches and potential frameworks, it became evident that the data collection and analysis needed to occur concurrently, one influencing the other in a spiral process.

The process of analysis began as soon as the transcripts for the initial round of interviews were completed. Early attempts involved identifying sections of the text related to particular events or experiences, the creation of a title for the story and classification according to the thematic elements of narrative identity (McAdams & McLean, 2013). These actions served to establish initial insights and familiarity with the data rather than direct focus on the research questions. Next, I attempted to use the analytical questions proposed by Frank (2010) as a means of attending to the work of stories.

These early phases of analysis afforded the opportunity to *'flirt'* with the data (Kim, 2016) in order to align my method of analysis with answering the research questions. Rather than fix my interpretation at a very early stage and inevitably risk losing insights, this process allowed me to embrace the potential of different ways to work with the data. Considering identity as a fluid entity, it was appropriate to refine and hone my understanding of the participant's stories.

Later analysis

Narratives have both form and function, are created in a context involving and influenced by human actors who are in turn influenced by social and cultural forces over time. The

framework applied in this research considered linear, relational, emotional and analytical levels (Landman, 2012) as represented in the diagram below (Figure 1).

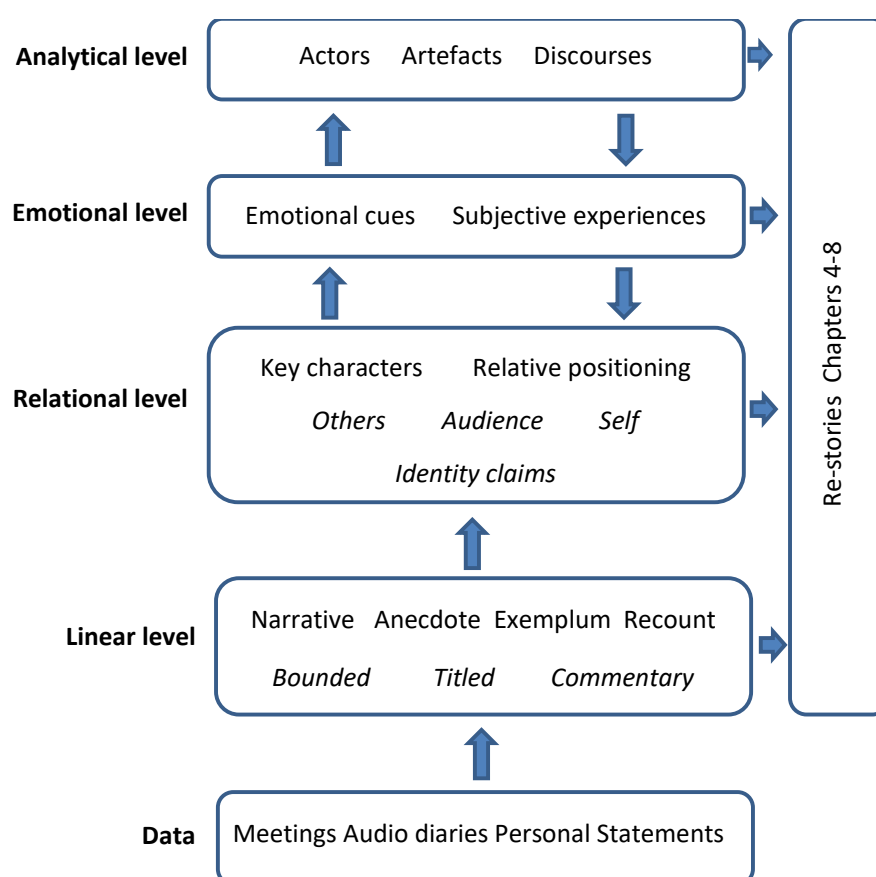


Figure 1: Multidimensional analysis illustrating the sequential steps from transcribed data to re-storied chapters

A data analysis frame (See Appendix 6) was constructed allowing for close analysis and recording of insights during the process. Stories within the transcripts were identified and labelled, the content described and a brief commentary was drafted. The stories were then subjected to the multi-level analysis outlined below.

The *linear* level of analysis concerned the structure of the story including the ‘*basic ‘facts’ as they are understood by the storyteller*’ (Landman, 2012, p30). According to the structural analysis of Labov (1972, 1997) the canonical, fully formed narrative must include an abstract, orientation, complicating action, evaluation, result, and coda. An alternative was to use the framework of casual spoken storytelling genres delineated by Plum (1988). This retains the principle of a ‘narrative’ structure but, in addition, recognises the capacity of

other forms of storytelling genres to illustrate aspects of the world and the self (Eggins & Slade, 1997; Patterson, 2013). Everyday stories, including those told here, have a complexity and messiness. While many appeared to lack the coherence and consistency of Labov's narrative structure, they could be classified as recounts, anecdotes, and exempla.

The linear level of analysis involved taking each transcript and identifying the bounded segments contained within the participant's responses. Some transcripts contained several bounded segments while others contained only a few. Each was titled using the words of the participant to retain their voice, and given an identifying code. These stories were then identified as narrative, anecdote, recount or exemplum according to the structural elements they contained (Plum, 1988) (See Table 3). Joining or bridging sections sometimes linked these and took the form of opinion or comment.

	<i>Beginning</i>	<i>Middle</i>	<i>End</i>
Narrative	(Abstract) Orientation	Complication - Evaluation – Resolution	(Coda)
Anecdote	(Abstract) Orientation	Remarkable event - Reaction	(Coda)
Exemplum	(Abstract) Orientation	Incident - Interpretation	(Coda)
Recount	(Abstract) Orientation	Record of events - Reorientation	(Coda)

Table 3: Plum's (1988) generic structures of spoken storytelling genre used for linear level of analysis

Analysis at the *relational* level began with the identification of the actors involved in the story including those individuals named and visible, as well as those individuals and groups who involved or formed part of the audience but who may have occupied a contextual position. It was then possible to consider the relationship between various actors and the relative positions adopted, offered to, negotiated or rejected across the study period. The questions I asked of the stories included:

- What kind of story is being told, drawing on Booker's (2004) analysis of plots?
- How does the narrator position themselves in relation to the audience(s)?

- How are characters in the story positioned in relation to each other?
- How does the narrator position themselves to themselves (and make an identity claim)?

(Developed from Riessman, 2011)

Analysis of the relationship established and enacted by individuals provided a means of exploring the power relations, social affiliations, hierarchy and position, key elements of the Figured Worlds theory (Holland et al., 1998). The consideration of relative positions required recognition and influence of so-called 'master narratives' that inform the habitual construction of identities in the space between storyteller and audience (LaPointe, 2010). As such, positions and the relationships they informed were transient, situated, multi-faceted and contested but accessible through consideration of performances. Identifying and evaluating dominant discourses and master narratives demanded a high degree of reflexivity. In certain circumstances, the interface between developing identities and dominant discourses is characterised by unquestioning acceptance in the face of large and small enforcements of what are regarded as the '*acceptable way*' to engage with the world (Thorne & McLean, 2003). These interfaces can also result in significant emotional responses enacted and included within the narrative and which informed the *emotional* level of analysis (Dornan et al., 2015).

Consideration of the feelings and emotions conveyed within stories provided a means of exploring the subjective understanding of the events and the crafting of identity (Zembylas, 2003). They are ubiquitous and 'every day'. Emotions, particularly those experienced as negative or challenging, have the capacity to both elicit and frame narratives (Rees et al., 2015). They bring into being relations between individuals, as well as between individuals and social structures (Harding & Pribram, 2009). They are regarded, from a constructionist perspective, as the '*glue*' that binds thoughts, judgments and beliefs to experience (Zembylas, 2003). Significantly this also opens the door to consideration of the moral and ethical nature of the experience and the ways in which this serves both to inform the person's identity and their motivation to inform future action (Roth, 2007).

Establishing emotions conveyed in each story was achieved with reference to the writer's Wheel of Emotions. This tool, based on Plutchik's (1980) psychoevolutionary theory of emotion, has been used by authors to express and relate the emotions of characters in their stories. For me, it served as a useful tool in identifying the nuances of the participants' expressions and naming the emotions (See Appendix 7).

The *analytical* level represents the drawing together of elements from across the various dimensions already completed and across the narratives over time to create a layer of meaning. In this research, I made use of the notion of Figured Worlds as a means of coming to understand how the participants formed their identities. Drawing from each of the preceding levels I established the actors, artefacts and discourses that made up the participants' Figured Worlds.

The final phase of analysis involved re-storying what I had been told. This is included as part of the analytical process since the objective in the chapters that follow is not simply to present data but to represent experiences and events in the lives of others. I am conscious that in presenting and representing the participants in this way, I have diverted somewhat from the traditional style of thesis writing. In support of my actions, I draw on the tenets proposed by Ely (2007) that emphasise diversity in reporting narrative research. In the act of reconstructing the data, I am conscious of the close, yet fluid, relationship between analysis and interpretation. As a result, the material in the following chapters represent versions rather than reflections of reality (Kim, 2016).

Throughout, I have resisted adopting a singularly 'thematic' approach to analysis which is typical among many narrative studies in order to adopt an analytical process that suits the research questions. Thematic analysis offers an effective means of determining the relationship between variables and was used to consider the functions of storied forms but this was not the central aim of this study (Ibrahim, 2012). Rather than seeking to establish gross similarities between the complex lives of these individuals, my aim is to illuminate and represent the unique and nuanced experiences that influence how people see themselves in relation to others and perform in those worlds.

Evaluating quality of narrative research

If any claims made as a result of this research are to be accepted, I must offer some justification and argument in support. Establishing the validity of claims about narrative research has resulted in an ongoing debate that is fundamentally informed by the standpoint of the commentator. Post-modernist thinkers have sought to challenge the assumptions of a pre-existing set of criteria for evaluating the quality of research while pragmatists and advocates of phronetic social science recognise the worth of engaging nuanced and reasoned evaluations alongside the notions of validity, reliability, and generalisability (Bold, 2012; Landman, 2012; Loh, 2013).

The legitimacy of these research outcomes rests on a web of inter-related threads. These have been used to frame the process explained in Figure 1 along with my actions as a researcher in order to achieve and demonstrate trustworthiness, verisimilitude, and practical utility.

Trustworthiness

Traditional methods for establishing and communicating the trustworthiness of the research outcomes are problematic when applied to narrative inquiry methodologies. The very nature of stories as individual, situated constructions means comparative techniques are of limited value. At a linear level, where storylines and plots have a similarity, triangulation across participants' accounts has been used.

In some narrative designs member-checking or participant validation has been used to confirm both the detail of the story told and the accuracy of the interpretation. Recognising that the purpose and interests of the participant are often different to that of the researcher, it is not always appropriate to assume that corroboration is validation. In addition, there is potential for respondent validation to result in situations that threaten the researcher-participant relationship (Bryman, 2012; Carlson, 2010). Each participant was given the option to review the transcripts on completion but only one person on one occasion requested this and made no comment on the record. The interpretations that

developed from each phase of the analysis were reviewed by experienced supervisors with knowledge and expertise in order to achieve peer validation.

Through the use of my research journal, field notes, analysis notes as well as a record of local and national developments in the context of my own and beginning nursing student identities I was able to construe rich and nuanced elements within the stories. These are designed to establish coherence, acknowledge my connection with beginning nursing students and illustrate my close understanding of their experiences and emotions. The intention is to contribute to existing understandings and provide evidence for the external assessment of credibility, authenticity, and plausibility of my outcomes.

Verisimilitude

Drawn together, these characteristics of both the data and the interpretation, amount to verisimilitude, the criteria favoured by Clandinin & Connelly (2000) as an assurance of quality in narrative research. Modern conceptions of verisimilitude demand that any reader assess the believability of the account and then establish the degree to which there is resonance with those foundationally involved with the study, its context and its outcomes (Loh, 2013).

Practical Utility

Rather than seek to identify and frame outcomes generalisable to a variety of contexts, it is the objective of much practitioner research to achieve practical utility that results in a contribution to practice and policy. The individual experiences of a small number of participants at points in history have the potential to illuminate the under-explained, map out the field of inquiry and inform those engaged in the practical activity of becoming (Clough, 2002). Andrews (2007) questions the notion that the narrative of a single or a small number of people reflects only the complexity of those individuals. Provided the focus is maintained on the 'unanticipated story' (Polkinghorne, 2007), there is scope to honour both the voice of the individual and offer a collective insight with practical utility.

Limitations

The aim of this study is not to establish generalisable statements. Rather, it was to explore the nature of early experiences of beginning nursing students. This demanded an emphasis on depth and quality in data gathering rather than breadth and representativeness. Whilst 12 individuals provided detailed accounts at the start of the study, only material that extended participants' stories throughout the year of study is presented here. The process of participant recruitment was not intended to establish a representative sample but to enable insights into the complexity of experiences and narrative constructions of beginning nursing students. I am conscious that the stories of male nursing students and/or those from more diverse ethnic backgrounds may have revealed other relevant insights.

I acknowledge the subjective nature of the analysis and interpretation in narrative inquiries. However, in order to assure any reader of the authenticity of my observations, I have employed two deliberate and reflexive actions. The first was to present myself and my interests as transparently as this thesis allows so a reader is better able to evaluate both the research process and the outcome. The second was to employ 'bridling' as a forward-looking approach intended to avoid making understandings too quickly. The consequence is that considerable time was spent reflectively and reflexively reviewing the data, establishing insights and then returning to the participants' stories. The results of this activity are observations and recommendations based on in-depth engagements with the data.

Conclusion

Exploring the way in which identity is developed in the early stages of a nurses career as they begin their formal preparation programmes can potentially be conducted in a variety of ways. Adopting a post-modern approach to the notion of identity has foregrounded some methods over others. In this chapter, I have outlined the deliberation and justification for utilising a narrative inquiry approach as an appropriate mechanism for addressing the research questions. There are no prototypical or lock-step narrative inquiry approaches, and even procedural guides (Chase, 2005; Creswell, 2007) only offer suggestions about potential analytical pathways. As a result, I have sought to justify the design of this study from a range of methodological elements that not only address the research questions but also respect

and represent the voice of participants in this significant stage of their academic, professional and personal lives.

Introducing the Narratives

My aim in the next five chapters is to strike the challenging balance between presenting and representing the participants and the details of their stories. These are used to provide a basis for the better understanding of identity development in the early stages of a pre-registration nursing programme, synthesising rather than separating (Polkinghorne, 1995) . The narratives of the five participants are presented here as interpreted accounts of the analysed data drawing on direct quotes to emphasise the meaning. What follows are separate chapters, each one dedicated to an individual participant. Each chapter begins with an introduction to the person as well as an insight into my own perceptions and interpretations. This is followed by a detailed representation of the stories that were recorded, interpreted and re-storied before concluding with a brief discursive coda.

Over the 10 months of the data collection period, each participant shared between 18 and 25 identifiable stories with me during 3 rounds of meetings and some additional audio diary submissions. They also allowed me to read the personal statements drafted to support their initial university application. This large amount of data has to be represented somehow. There is real risk that, in the course of analysis and interpretation, detailed personal exchanges between me and the participants are '*butchered into fragmented quotes*' with the resultant loss of the important holistic context (Kvale, 1996, p182). I sought to represent each person, their experiences and my interpretations, mindful (reflexivity) of the limitations of *any* act of representation or 're-storying' .

In the sections that follow, I have sought to integrate the voice of the participants by including their own words whenever possible. Ungrammatical and colloquial speech has only been 'tidied' in instances where transfer of the original, aurally delivered story, is difficult to read. I have avoided reproducing extended passages of transcribed dialogue, conscious that, in the process, I risk '*smoothing*' the stories such that they become arbitrary interpretations (Kim, 2016, p191).

As discussed in the Methodology chapter, one of my objectives is to honour the voices of the participants whilst offering an interpretation of the stories they told, in different forms,

about the experiences they underwent and the influence these had on their becoming. In doing this, I sought to respect the 'truthfulness' of every story as an expression of each person's truth (Richards, 2011). This is not a simple undertaking. Geertz (1988) famously observed the ethnographer's dilemma, one shared by many qualitative researchers (Maclure, 2003), of the need to simultaneously position oneself in the writing to adopt both '*an intimate view and a cool assessment*' (p10). I have a responsibility to the participants for how they are represented here and to the reader who has this as their only means of relating these becoming experiences. The stories presented here cannot be read as factual accounts. Neither can they be dismissed as fictions and fabrications. They are stories of events that may or may not have happened in the way they are told. Elements will have been emphasised while others are omitted as the teller seeks to perform their evolving, becoming identity. They represent the teller's perspective towards experiences and as such, have validity as expressions of '*their truths*' (Richards, 2011, p787).

For practical purposes, the bounded stories are identified throughout by two and three element codes. Those told during the first, second or third meetings are prefixed with 1, 2 or 3 respectively. The initial of the participant's pseudonym is followed by the sequential position of the story for that person resulting in a unique identifier (e.g. 2B7 was from the second meeting with Beth and was the seventh bounded story identified). Interruptions in the sequence represent stories subsequently identified as opinions or comments with less validity. Interjections from me are denoted by the abbreviation R: (Researcher). The same transcription convention employed to convert the audio recordings to text was employed in order to record key paralinguistic features (See Appendix 5).

Chapter 4 - Andrea

Introducing Andrea

My initial impression on first meeting Andrea was that she seemed rather timid and apologetic, with frequent nervous laughs and pauses in her speech. This reoccurred during the initial stages of each of our meetings but did not disguise a clear determination to succeed in her personal and professional ambitions. From the outset, she had stories to tell and the research process gave her a forum to do this and a new audience to engage with. Concluding our first meeting she explained her reason for agreeing to take part in the research.

'I think I wanted to do this because I think I'm slightly different from some, most people probably, most students that come here are like – "Yeah, I wanted to be a nurse all my life" – kind of thing and mine's totally different...'

Andrea was 35 years-old when she started the pre-registration undergraduate Adult Nursing programme having successfully completed an Access to Health Care course at the local further education college. She had five children and had enrolled as a full-time student. While she acknowledged that one of her friends *'thinks I'm a bit selfish'*, Andrea felt this is how she had to be, telling herself and others, *'Right! It's my turn now'*.

Like each of the five participants, Andrea and I met on three occasions during her first year. She also provided three audio diary entries covering the period from October to December addressing the start of her first clinical experience. This resulted in 25 identifiable bounded stories, the majority of which were categorised as Recounts (recording and orientation towards events) and Anecdotes (recall and affectual reaction to remarkable events).

Pre-course personal statement

Her personal statement, used to support her original application, contained three short stories about her recent study experiences, the topics Andrea believes are relevant for nurses to learn, and support for her pre-course identity claim to be an altruistic and caring person. The final vignette concerned her volunteer work at a charity for women who had

experienced domestic abuse. Along with other aspects of the statement, it served to offer a context for an explicit declaration of what she perceived to be the necessary characteristics of a nurse, namely caring, self-sacrificing and hard-working illustrated with reference to her own work-based (Community Carer) and family-based (Mother) roles. In these instances, the term ‘caring’ was used as an important identity marker, ‘*a term via which a facet of identity can be construed*’ (Baxter, 2011, p22) and which served as a core descriptive (Price et al., 2013) and may be considered a threshold concept (Clouder, 2005).

The personal statement stories in combination suggested that a place on the course represented the natural progression for Andrea now that she had ‘*the courage to start [her] journey into nursing*’. There is only a vague statement of her future goals which suggested the act of *becoming* a nurse might obscure the impression of what *being* a nurse in the future might involve. Her emphasis was on potential as she was about to ‘*enter the world of nursing*’, conveying the image of standing on a threshold with a quest waiting, challenges to overcome and an ambition to achieve.

Meeting in Month 1 (Pre-clinical)

At the start of our first meeting, Andrea told me her abridged life-story (1A1), emphasising experiences that she felt were pertinent and of interest in the context of the research. She began very frankly with the death of her father four years earlier, making immediate references to the nurses who cared for him.

‘Eventually, he died at home but all the nurses around him were really, really good. There were a couple of moody ones in hospital..’(1A1).

Andrea’s father seemed an important influence in her self-concept both in terms of what she had chosen to do and the person she was becoming. He had wanted her to use some of her inheritance ‘*to do nursing*’ and was evidently extremely proud of her achievements on the Access programme.

‘...he’d get them [other family members] to ring me and tell me how brilliant I was.....My Dad was really proud of me because I was on my own with two children

then, um, and he made a really big fuss about it, about how great I was doing it and that I'd make a really good nurse...'(1A4).

Andrea had worked in a number of jobs over the preceding 18 years including on a production line and in an insurance office. She suggested these were jobs of necessity rather than career decisions, acknowledging *'I didn't really have a clue what I wanted to do'* (1A2). She completed an Access to Higher Education course but was then told by her *'abusive partner'*, *'I couldn't go to university because I needed to go out and earn money'* (1A2). It was Andrea's personal experiences with her children and her need for a casual job that prompted her to seek *'care work'*. She mentioned an affinity with a positive role model (Mother's friend who was a nurse, had four children and had progressed her career) and was impressed by the midwives who had cared for her during her own pregnancies but, at this point, offered little insight into her view of nurses and nursing.

Andrea returned to the story of her father's death (1A4) to characterise nurses she felt were *'just getting on with their jobs'* but were not always as caring as she might have expected. This contrasted with how she saw herself, an important identity claim, and the sort of person she believed a nurse should be.

'I've always been a kind [laughs], big myself up, um kind of a caring person. I do always go that extra bit for people. Um, probably too much sometimes as I do get, well I have got taken advantage of...' (1A4).

Her next story is used to frame the present as a break from the past and a rediscovery of her former self as Andrea tells of her most recent relationship. This is a thread she returns to in our second meeting (February) but not in our third. In story 1A5 she engages in exploratory narrative processing (McAdams & McLean, 2013), concluding that *'I must have been confident before I met him'* but that she was *'kind of trapped'* and *'like a shell I think before'*. There is a contradiction as Andrea suggests that her changing self occurred *'gradually, well, almost instantly'* in order to reinforce the notion that she had always been *'caring'* and *'determined'* but this was stifled by her partner. Andrea intimately combines her sense of self as a person and her anticipated self as a nurse through these initial stories. She authors the identity of the nurses she had come into contact with in terms of character and

competence (*'they were really, really good and they were really nice people'* 1A3) and seeks to align herself through the selection and performance of these early stories.

During our first meeting, the only story Andrea performed with a narrative structure had a muddled chronology but concerned her academic career and journey as a learner. In the context of her personal circumstances, Andrea's story was one of redemption (McAdams & McLean, 2013). She characterised herself as *'just one of those average kids'* who was not pressured to do well at school (*'I think we were just left to our own kind of devices in that way'* 1A6) and completed a GNVQ in Business without any real goal (*'I don't know why.'*). Her inability to continue with an initial Access course was attributed to her personal circumstances which, once resolved, appeared to have opened up possibilities and provided an opportunity for the expression of her rediscovered determination. The story was presented as transformative, where emotions of *'surprise'* and shock emphasised the meaning making purpose it served.

'That was a bit tricky to start with but, my first one I got a distinction in so I was like, Wow [laughs] what happened?' (1A6).

Andrea makes an identity claim of a person with the potential to study at university (*'I could actually do it.'*) but with an appreciation of the ongoing internal dialogue concerning future unknowns (*'Am I going to be able to cope? Will I understand everything?'*). She appeared to be enjoying the image of herself as someone who had arrived at a threshold which she saw as an achievement in itself.

'Obviously, I don't want to drop out but it's, yeah a good feeling. Kind of being recognised for being in the situation I'm in I guess' (1A4).

The important characters in Andrea's initial stories were her father, who embodied pride, drive, motivation and support in contrast to her former partner, who was cast in the role of the adversary in a context where development, ambition, and achievement were stifled. Andrea's professional identity, at this stage, and in this context emphasised potential and anticipation. Interestingly, her preliminary professional identity was constructed around personal commitment, and images of those who nursed her father rather than direct reference to experiences in her own role as a Community Carer.

Month 3 (Beginning practice)

Andrea's next four stories were included in three audio diary entries over a six week period. The first of these, A8, was recorded following a visit to what would be Andrea's first clinical placement. The purpose of the anecdote was to claim authenticity as a Student Nurse and rehearse the reality of her situation through her expression of a range of emotions. These included statements about feeling disappointed, glad, excited, scared, distressed, fearful and proud in various situations. Her uniform and the reaction she received from ward staff appeared to have significantly assisted with Andrea's sense of legitimacy.

'We had our uniform which was really exciting and I feel, I don't know, it's kind of real. [Laughs] Well it is real.....the nurses and doctors and consultants that were on the ward at the time made me feel really welcome as a student and as a person'.

Each of the events she recalls (hospital induction, the sights, and sounds of visiting the ward) are presented as novel and worthy of inclusion in a performance of relevant experiences. I recognised these as significant from my own experiences as a student and a nurse educator. Andrea's anecdote was an opportunity to show she had shared experiences that may reasonably be assumed to be universal in the course of becoming a Student Nurse.

A significant learner identity marker was evident in story A9.

'So, but yeah, I'm managing. Fitting it all in quite well Um, handed in the first um rough copy um the first half of the first assignment um and I got 48 out of a hundred which I was quite happy about [laughs] because I didn't fail.'

She made an expression of agency in being a dedicated learner, making time amongst the other commitments of parenthood to complete her academic work. The sense of agency is driven by her perception of success in light of the commitment that Andrea regards as relevant from both an academic and professional perspective.

'Um, since starting university, I've had probably, maybe five or six evenings of not actually doing my work'.

She concluded by commenting that *'as a person, I'm extremely proud of myself'*, a position informed significantly by her academic and professional achievements.

Andrea's next two stories (A10 & A11) originate from clinical experiences, the first as a recount of events and the second as a 'rite of passage' anecdote. On her first day, Andrea recalls the actions she took to 'fit in' by bringing a gift (chocolates). She was aware that it was *'Kind of a bribe I think'* seeking to gain early approval and recognition from the ward staff. In doing this, Andrea was engaging in a well-established social practice intended to promote social ties through a symbolic interaction about her relative position and power (Ward & Broniarczyk, 2011) as well as conveying messages of the values she foregrounds (High energy snacks, eaten 'on-the-go' by hard-working, self-sacrificing staff).

Andrea assigned an importance to her uniform as a social symbol at the start of her third audio diary entry (A11) expressing her sense that, wearing it, elicited an unfamiliar response from others. She characterised this as *'respect'* suggesting *'they see you as someone to depend upon'* and that *'I've discovered that people like nurses.'* She expressed a feeling of being an imposter in her recognition that the uniform established social expectations and attributed her with characteristics that she did not possess (knowledge, technical skills).

Andrea performs what she believes is expected of her in the new role of nurse. It seemed important that she *'stayed professional'* by dealing with her emotional reaction to the death of a patient once she had got home and not while still on the ward. *'I'm OK with it all now'* is offered as a statement that she now understands the nature of illness and suffering that she had previously not considered (*'it's opened my eyes a lot to life in general'*). Her sense of agency in these situations is focussed on being able to *'make a difference by making them comfy'* and a realisation that *'before, I think I was just aiming to make everyone better, um which obviously isn't possible for many people'*. These stories represent the early steps of socialisation where she forms images of being professional alongside a growing realisation of her own innocence. Andrea's idealised notion of nursing and health care represents a concern of many becoming nurses, revisited during our second meeting (Wood, 2016).

'I thought that I could just go into hospital, be a nurse and make everyone better, and everyone goes home and everyone's happy'.

From her previous personal experiences, she knows that suffering and distress are features of the clinical world and yet these were overlooked as Andrea began to develop a sense of

herself as a professional. At this stage, these contradictions did not appear to cause her concern or embarrassment but later stories began to reveal some tensions.

In A11 Andrea describes overhearing a doctor informing a patient and her family that they had diagnosed lung and brain tumours. While not directly involved, Andrea's stated reaction was *'I just wanted to run away'* because *'I think it brought a lot home, a lot of memory'* [of her father's diagnosis]. She was occupying the space between personal reaction and professional expectation, looking for someone to tell her what to do, knowing she could not avoid the situation.

'Yeah, so I pulled myself together after thirty seconds [laughs] and went back to that um bed area and just asked them if they wanted a cup of tea or anything' (A11).

Here she performed a stereotypical image of what it is to be 'professional' alongside her personal response, the former taking priority in this context. At this point, Andrea emphasises agency over self-exploration, the performance of an action rather than meaning making which she undertakes in our later meetings (2A14 & 3A23).

Andrea continues to make clear comparisons and affiliations with HCAs and nurses. Using her own HCA experience as an apparent reference point, she commented finding *'the nursing assistant's role a lot more relaxed than the nursing role'* as they were *'chatting and checking their phones'* (A11). Her disapproving tone at this point was very interesting. It served to communicate a distinction between herself and the HCAs on the ward. It was a critical part of her performed claim that she was no longer a part of the HCA group. However, she also claims a distinction with some of the registered nurses who are *'a lot more firmer'* in relation to the *'professional bit in them'*.

'I was quite shock- not shocked, I don't know what, at how er, kind of um cold the nurses are compared to the HCAs.'

The numerous hesitations in the delivery suggest Andrea's embarrassment at the situation she is describing and a discomfort in terms of her relative positioning between these groups rather than part of either.

Meeting in Month 5 (Returning to university)

The consequences of tensions embedded in the audio diaries are performed during the subsequent stories told a few weeks later during our second meeting.

'I had like a bit of a mini-breakdown that just made me think, what am I doing? I went to placement and then it dawned on me that everyone is sick. [laughs] OK, it's a hospital, you'd think that anyway. But (.) just really poorly people and we had quite a lot of young girls, sort of my age, erm, which was (.) I don't know, it was just hard' (2A12).

It is here that the nature of the nurse-patient relationship becomes an identity marker. Andrea characterises the interaction she had with a person who died as *'like friends'*. She reported that providing physical care was *'awkward'*, possibly because of age proximity and the similarity to Andrea's own personal circumstances. She was conflicted in how to respond and react to these 'patients'. Engagement with patients 'as friends' proved to be challenging however, at this point, it was likely to be the only way Andrea could conceptualise a caring relationship.

Andrea reported that *'She [one of the people she was caring for] had a problem with some of the nurses'*. In this situation Andrea chose not to align herself with the ward staff. This was a story of communion as Andrea began to establish a new form of relationship characterised by personal closeness. There was, however, an associated dissonance because of *'a preconceived notion that to be professional is to be distant, detached, aloof and cool'* (Stein-Parbury, 2009, p27) which informed A11. Andrea seemed comfortable to perform what she represented as a naïve and revealing position because she felt she now had more insight. She did not initially dwell on *'the death thing'* but acknowledged she had not really considered *'the whole illness part before then, how ill people are and how lonely they are.'* (2A12)'

In story 2A14 Andrea continues to represent herself to herself and emphasise the degree of agency she had developed following the incidents reported in A11 and 2A12. This resulted in *'a lot of crying'... 'almost like having really bad depression'* (at home) and she *'dreaded going in'*. She questioned herself over her abilities to continue (*'I don't know if I can do this today'*)

before suggesting *'I've kind of just got out of it'*. The mechanism of storying was used here to enable Andrea to author herself in a world where she had control of her emotions even when she did not have any control over the traumatic events in other people's lives.

One of Andrea's most significant revelations concerned her sense of self in relation to other health care professionals.

'I don't know what I was expecting them to be, but they are just normal everyday people (.) um, some in similar situations to me.'

By this, she was referring to her personal social circumstances as a single Mother. In story 2A16 Andrea moved from a third to a first person voice suggesting *'we are just normal people'*.

'I can be a nurse because they are normal people.'

This was one of her first professional identity claims. The emotional tone was one of surprise and excitement at the potential for personal and professional development. The gap between how she saw herself in relation to others was narrowed and performed in other stories during our second meeting (2A20). For example, she performed a defensive reaction to critical comments about nurses and nursing work.

'They're not off having a cup of tea. Don't get larey [rowdy, unruly] with them....I'm like, I'm just a student nurse. I'm sorry, I can't. There's nothing I can help you with. Erm, I'll go and speak to my mentor and come back to you.' (2A20)

There was evidence of annoyance and defensiveness in her tone and, since there was a sense that part of this criticism is directed at her, a tentative desire to establish herself as part of the nursing group but also acknowledging her status and difference.

The tensions of her Student Nurse identity were clearly articulated in an exemplum that draws on numerous untold incidents from Andrea's first clinical experience and her position between what she perceived to be the policy informed world of the university and the practice informed world of the staff she was working with (nurses and HCAs).

'we're taught it properly here [at the university]. Erm, the hospital staff are taught it but they then kind of (.) change it to the easier way.'

In 2A19, ward staff were portrayed as the obstacles to the transfer of policy guidance into practice, insisting on their own way of doing things.

'you don't really want to grass people up either if you know what I mean. But then you don't want patients being hurt or the staff. So'

The story was one of resistance towards conformity, and an expression of the tension between wanting to adhere to what had been taught whilst also fitting into a new team as a neophyte, and developing the self-confidence to do this. At this point of intersection between worlds, individuals must author their identities in an attempt to 'answer' the conflicts that exist (Peña-Talamantes, 2013).

'No....I can't, sorry, I'm not doing that. We're not allowed; I'm not getting into trouble; And I don't want to hurt the patient.'

Andrea acknowledges the positional power of the ward staff but authored herself as a safe practitioner who is not prepared to be sanctioned for the sake of compliance. In this circumstance, the policy and 'student' identity provided her with a source of resistive power. This was one of the first stories where Andrea acknowledged the impact of, and her own capacity to exercise power as part of her ongoing development.

Reflecting on having received her first full set of academic results, Andrea stated *'it feels different now. The whole sort of atmosphere feels different'* (2A17). This seemed to be the result of differences in the level of success amongst members of her group.

'I'm OK. I'm happy, erm I passed and I can do it. But I don't know if it will ever go, but there's always that thought in my mind, erm, Am I clever enough to do this?'

Andrea made the identity claim telling herself she was OK, for now. She also performed the tension of her own position in relation to fellow students who were considering withdrawing having not yet passed their assignments.

'I'm trying to push her [fellow student][laugh], you know. Do it!'

In this context, she adopted the role of motivator not wanting to see people who had quickly become *'quite close friends'* discontinue, possibly because this would make real the risks of failure.

From a personal perspective, Andrea made a significant identity claim as a result of her recent clinical and academic experiences.

'I think I've got more power than just being a single mum with five kids' (2A18).

She recounted how she dealt differently with her reactions to her ex-partner, conveying a sense of liberation and the absence of negative emotions which characterised previous stories involving this influential character. Andrea used her identity as a beginning nurse, contrasted directly with the persona of her ex-partner, to convey agency and a degree of redemption in the way the story was told in this context.

'I think it's just how I've worked it out in my head.'

The uncertainty suggests this was a story she had told herself as a mechanism for developing her own self-esteem.

Meeting in Month 8 (Nearing year's end)

During the course of our final meeting, Andrea told five bounded stories, three concerned clinical experiences, one about her recent Dyslexia diagnosis and a general concluding story about how her sense of herself had changed. The first two clinical stories focused on inter-professional relationships, with only tangential but intriguing references to registered nurses.

In the first, Andrea chose to tell of the interactions she had with a medical consultant where she achieved a sense of triumph through quasi-passive resistance.

'Erm, so, I've been working closely with consultants and I've found (.) that probably the maj- ninety-nine percent of them are very nice people. They're down to earth, erm (..) they're happy to teach...Anyway, so one time [laugh] I forgot to give him the patient's notes before I went out and called the patient which he told me to go and call the patient, he didn't mention the notes. Anyway, so when I did that, when the patient left, he got really quite angry with me.' (3A21).

Andrea's initial emotional response of feeling *'really upset'* was transformed into expressions of resistance. She acknowledged the perceived hierarchy and a certain inevitability of her position but had presumed a level of reciprocal respect. When this was not forthcoming, she interpreted the consultant's behaviour as unjustified and rude and seemed particularly wounded by his accusation that she was being *'unprofessional'*. At the time she could not rationalise the situation and so used the second incident to demonstrate her progression.

This situation suggested a developing awareness of the relationship between senior doctors and junior nurses being rule-bound.

'so I thought, Right. OK, we're going to play this game are we?'

It has been suggested that this 'game' is still being played more than 40 years after it was first described in 1967 and still influences the professional identity of many nurses (Holyoake, 2011). Andrea would *'make a point of being overly friendly and happy, like Morning!'*, and in the process learned the rules that enabled her to achieve association and acceptance.

'They do, they [nurses] basically just put up with it.'

She was frustrated and disappointed at the permanent nursing staff. While she understood that this was often the path of least resistance, she cast them as capitulators, unwilling to challenge this behaviour. At this point Andrea was being socialised into the 'game' as well, performing a position in the health care hierarchy that is evident in the stories told by other participants.

Another story of dissatisfaction with nurses was performed in an anecdote where Andrea was asked to assist a patient to the car park and the tension that ensues. The story focused on the way Andrea perceived how nurses treated HCA's without recognising the contribution they make. She positioned herself as different to the nurse in this story (much like the consultant in 3A21) and aligned with the HCA role with which she was familiar.

'I won't be talking to them like that.' (3A22)

She authored herself as a more reasonable and respectful person. Unlike in A11 where she appeared to be suspended between two groups, in both 3A21 and 3A22, there is fluidity in group association as Andrea sought to perform her dynamic identity.

Returning to the thread of working with people who are dying (A11 and 2A14) Andrea acknowledged that in our research meetings, she was not talking in a way that she might do to anyone else (3A23). Seemingly she was caught in the space between public expectations about the way someone (public) should react to and describe being with someone as they die and the professional perspective which she characterises as being 'OK' with it. By suggesting to me *'I know that sounds weird'* indicated that she was not totally comfortable

with her current position. She worked to present herself as someone who was adjusted and reconciled to the nature of death as a part of the nursing experience that has to be managed. Her use of technical language (*'morphine driver', 'DNAR'*) was intended to demonstrate her familiarity and integration. Of particular note was the significant lack of emotion in the delivery of this story when these experiences are known to offer significant challenges from both a personal and professional perspective (Ek et al., 2014). It was intriguing that at this late stage in our meeting, Andrea seemed unsure of how she wanted to perform her identity in relation to this critical aspect of nursing practice. She may have shifted intellectually from her position in A11 but the statement *'I think you know deep down that you can't save that person, you can't make them better'* suggested she was still working to rationalise this and integrate it into her sense of self as a nurse.

In her final story explicitly addressing her university persona, Andrea recounted the events of the preceding five months leading to her dyslexia diagnosis. In the telling of the trials, tribulations, and reactions, she was working to make an identity claim based on her own insights.

'Actually, that means I'm special.' (3A24)

She was engaged in rejecting and resisting the traditional medical/deficit label of 'disability' by framing herself in contemporary terms. The work of Evans (2014) is helpful in understanding the various positions Andrea was adopting. Simultaneously she represented herself as an Embracer (I have dyslexia), as a Passive Engager (I have some particular difficulties) and a Resistor (I don't need to tell everyone).

'It's just my learning....it doesn't make a difference to me working.'

While Andrea was coming to understand herself in a new way, as a person with dyslexia, she made a conscious effort to separate her persona as a university student and her developing professional identity.

Our contact ended with Andrea recalling three instances that occurred in separate contexts but which she used to illustrate to me, and herself, that her confidence had improved over the past seven months. In her telling, Andrea drew together university, clinical and personal worlds to illustrate the global impact on her identity. Challenging a fellow student, overcoming the fear of appearing *'stupid'* on placement and successfully advocating for her

son in a school situation, were all tales of triumph over her previous tendency to accept situations without challenging them.

'I think I've got the confidence. I speak out more about if there's a problem or anything like that...Whereas before, I would have been like, OK [nervous laugh].'

(3A25)

The self-image performed by Andrea was one of a capable person in various situations, an engaged learner who takes active responsibility even when there might be a cost in terms of the perceptions of others. Importantly, there was evidence that her developing persona in the professional context was increasingly influencing how she saw herself in personal and academic situations. Her abilities to tell stories of success served as evidence, both for her and her audiences, of how she had changed during the first year of her nursing programme.

Coda

Throughout the course of our meetings, Andrea casts herself as someone increasingly comfortable with the choices she had made. Her initial stories emphasised how her former identities may not have been a true representation of the person she was or wanted to be. She performed a calm resilience and a desire to take the opportunities that resulted from starting her journey to becoming a nurse.

At points, the tensions of existing between the worlds of clinical practice and university as well as between the roles of HCA and Registered Nurse were palpable. The opportunity to story her experiences provided Andrea with a mechanism for reflection but without the pressure to achieve a resolution. The stories allowed her to be contradictory and inconsistent as she engaged in the process of working out and performing who she wanted to be.

She admitted to her own naivety as a means of showing her learning potential. The new context of being a nursing student had required her to reflect on the observed actions of others as she established what was important in her own view of nursing. Her sense of affiliation with HCAs rather than qualified nurses suggested she was engaged in a journey, wishing to hold on to what she understood from her past as she tried to make sense of how she and other people should behave in her future.

Chapter 5 - Beth

Introducing Beth

Unlike Andrea, whose journey to her nursing career was characterised by the triumph over challenging personal circumstances to achieve a long-held ambition, Beth's experience was more opportunistic and serendipitous. She initially described it as, *'I just had a bit of an epiphany'* (1B1). Her decision to start a pre-registration nursing course was made comparatively late having originally planned to undertake a PGCE, building on her previous training as an Early Years Teacher and Forest School Leader.

As one of the first people to respond to the study invitation, she struck me as someone interested in both the process as well as the content. Asked at the end of the first meeting how she had found the experience, she admitted *'It made me feel (...) a little exposed I think. Because I found that I was revealing stuff to myself I hadn't quite admitted yet'*. This sense of exposure did not prevent Beth from attending future meetings and over the course of the first year, she shared 18 bounded stories including 11 anecdotes but only one narrative.

Beth was a fast and entertaining talker, jumping quickly between stories and occasionally returning to points she had previously mentioned to elaborate with comments that had occurred to her in the process of storying her life and experiences. She was expressive, employing language and tone that sought to convey passion and commitment. Occasionally she would employ reported speech which may or may not have been accurate. Occasional inconsistencies emphasised that these stories were not factual accounts but interpretations of events from her own perspective. Beth had opinions and valued the opportunity to voice these, giving the impression that she was using our research meetings as an arena for reflection and intellectual exploration.

Beth was 43 years-old at the start of the programme and had chosen to study part-time. Previously she had worked for 12 years as a Communications Manager with a multinational petrochemical company. Having achieved financial stability, Beth *'packed it in'* admitting she

was not getting to see her children due to the travel demands. At that point, she was still unsure of what she wanted to do and this led her to undertake an Early Years education course and train as a Forest School Leader.

Beth's educational experience followed a typical pathway from school to university where she studied anthropology. A job as an Anthropologist was her initial career choice which she viewed as ironic given her subsequent move into the corporate world. Clearly, she enjoyed her first university experience. This gave her the chance to engage intellectually, provided a context for meeting others with similar perspectives and achieve a better sense of who she was as an individual.

*'I'm quite a theoretical person. I really enjoy mulching something up from what I've got out of a book and really challenging ideas and thoughts and theories.....When I went through my Anthropology degree, it was, it was **wonderful** because I finally found that 'Oh my gosh, other people think and feel like me', and I think that gave me confidence in my academic perspectives...' (1B4)*

As a result, she developed a confidence in her learning and academic abilities. Her initial concerns stemmed from the fact that she had no direct clinical experience to draw on. Her decision to switch careers was a much riskier option, creating a context that was very different to some other participants.

Pre-course personal statement

Beth's personal statement was unique among those gathered having not been written to support a pre-registration nursing application specifically. As a result, there were some disciplinary differences as Beth sought to convey an image of herself as a suitable candidate for a teaching course. She immediately draws on the opportunity available to all teacher students, of referencing their own experiences as a student (Furlong & Maynard, 1995). This approach was designed to demonstrate an insight and establish an affinity with the Admissions Tutor. Beth wrote in a story-telling style, rather differently to all the other participants. Reflecting on her own experiences of school allowed her to begin the story at a much earlier stage so that the persuasive nature of the text has the weight of history behind it. The first section employed a journey or river narrative hinting at being carried along, not

necessarily to a place that was desired but making the best of things, until the time was right to take control and make a definitive decision about the course. That this definitive decision ultimately changed acted as a salient reminder that personal statements, like all such communications, are contrived and crafted to serve a particular and context-specific purpose (Ding, 2007).

There was an appreciation that her initial ideas about teaching might have been a little naïve and that with adulthood comes a more realistic notion. This was used as the basis to then state the perceived suitable personal characteristics, in much the same way as the nursing applications. These characteristics are early identity claims that include commitment and dedication, a focus on individuality and a desire to assist people to achieve their full potential.

The final section was a story of personal achievement and motivation with a subtext that Beth was not content with the status quo. The two examples were designed to show her as a resilient character that set herself challenges and doggedly worked toward achieving them.

Meeting in Month 1 (Pre-clinical)

Beth began our first meeting by suggesting that she did not have *'a very tangible story'* (1B1) before proceeding to introduce a number of insights into how she saw herself. Firstly she established that she had already studied Anthropology, suggesting that her journey to the nursing course might have had its genesis in a module that considered the conceptions of self, illness and biological definitions of the body. Her objective appeared to be conveying that she understood learning in Higher Education and what it is to be a student. Her identity claim was associated with the behaviours of a good student. Beth was uncertain about the nature of nursing and so told the story in this way to legitimise herself in the academic setting.

'And I was always the one in class that used to get on everybody's nerves because I'd want to go further and challenge and talk about it and the implications and think about it in action..' (1B1)

The story continues as Beth recounted how she made her decision about nursing. She presented herself as a risk-taker who still harboured doubts but who had experienced ‘an epiphany’.

‘I thought, do you know what, I’m ending up doing the same thing and I’m tripping up and I’m just being shoe-horned down a route because that’s what I’ve done, so it seems the next logical step.....And so I just kind of stuck my finger in the air a bit and looked at all the aspects of things that interested me and fascinated me, and pulled them together and thought, Do you know what, I’ll have a go at this one....It really was up to the nth hour and I don’t know, it just stopped me and I thought, Oh my god. Yes, Nursing.’ (1B1)

In the sections after the story, Beth claimed her uncertainty about the nature of nursing was due to its uniqueness (*‘I think it’s quite a personal thing’*) and dependence on experience (*‘it is whatever you bring to it’*). She performed this by suggesting *‘if I’m truthfully honest, I still don’t think that I could tell you what it [nursing] is. I don’t think I could articulate that even now.’* There was a sense of vulnerability that Beth had started a programme with little clear professional or practical insight which may have been why her academic identity claim was made so strongly at the outset.

Having acknowledged her ambivalence about nursing, Beth’s second and third stories were an attempt to put her specific decision in context. In doing this she seemed keen to demonstrate growth and maturation, shifting her life goals from material focus to existential ambition. Talking about her early education and family expectations, she disclosed that *‘Erm, I’d see, erm, people from school, who weren’t necessarily the high achievers, erm, becoming nurses. So I always just assumed that it was the, what you do when you’re not really very bright [laugh]’ (1B2)*. Beth had to adjust her evaluation; something she felt was only possible once she had succeeded in a more traditionally recognised academic and business environment. Brought up by her mother in tight financial circumstances, Beth described herself as *‘a top student’* who *‘went off the rails’* and *‘let it all go to nothing’*. She was driven by a desire to acquire *‘status symbols’* and *‘when people say “What do you do?”, to be able to come back with something that people actually listened to, I, I guess.’* This was a story of enlightenment where Beth was performing her growth as a person.

'I've got nothing to prove now and whatever I do can be a totally hedonistic choice so the status was no longer an issue. And now that I've started it, I've suddenly found that, my gosh, I read this very wrong, that nurses really are quite something.' (1B2)

The catalyst for this growth was initially attributed to the birth of her children but as 1B3 continues, it became clear that Beth was representing herself to herself whilst still trying to justify her career change. She disclosed that *'nobody else thinks I should be doing it incidentally. My mum thinks that, erm, it's not fair on the kids because I wished that she'd been around when I was younger and that I'm putting too much pressure on myself...'* (1B3). As the story progressed, she restates the identity claims made in her personal statement written a few months previously.

'I need a driver and a focus to feel as though I'm progressing...for my own self-worth....and this is really gripping me at the minute and I'm liking it.'

This suggested that, at the time, Beth was less focussed on the ultimate goal of being a nurse than on the journey to becoming something new.

The image of Beth as itinerant rather than fixed was presented in both literal and metaphorical terms in the next story. This was her *bildungsroman*, a tale of self-cultivation that results in personal and cultural maturation. Consequently, it has a strong sense of significance for how Beth sees herself, represents herself and wishes to be viewed by others (as a philomath). In a short narrative, she told of her previous university experience and her exposure to new philosophical perspectives. There was a palpable emotional charge to the way she told the story with expressions of anger, acceptance, and contentment resulting in a sense of communion. In the process, Beth made and repeated identity claims about herself as a learner, attempting to validate why she was embarking on yet another journey.

'I just love learning. I thrive on learning. Erm, I could, I could be a lifelong student I think, to a certain extent...So it [original university experience] gave me some, some routes in, from just being a general swat and enjoying studying, to actually, No, this is what I'm about, and I want to keep going with it' (1B4).

Having established the apparent stability of her identity as a student, Beth's remaining stories in our first meeting (1B5 & 1B6) addressed her apprehension in relation to her

professional self. She expressed this in explicit slang terms suggesting *'I'm confident academically but I am so::: papping it when it comes to the rest of it because I am out of my depth'*¹. She expressed a sense of awe and nervousness when considering the practical skills of some of her fellow students during clinical skills sessions.

'I, I shut up in the practicals...And I'm feeling the rug has been pulled out from underneath me a little bit...I always just assumed that I could do that, I could do that. But I'm, yes I'm realising just how little I know and can do at the minute.' (1B5)

Beth's apparent insecurity about this prompted her to make reference to the identity marker of herself as a caring person (*'And I **do** really care about people, I do.'*). The persuasive nature of this statement was reinforced when, in the subsequent story, Beth told of how she risked ridicule to ensure that someone at the roadside was not injured. Using three examples, she presented herself as a suitable person to undertake a nursing programme through her self-evaluation in relation to this critical identity marker.

'I know I care about people and I know I care about people more than other people around me.' (1B6)

Meeting in Month 5 (Returning to university)

Enrolled as a part-time student, Beth completed a single theory module and a short 7-week clinical placement between our first and second meetings but her stories suggested a close intertwining of various aspects of her life. She began our second meeting by suggesting *'I don't have, I don't think I've got specific stories. I can't pull up anything other than um..I think the who- whole, I can cope with the whole death thing a bit better'* (2B7). Beth then continued to tell of her recent trip to visit a friend she had not seen for a number of years and who had cancer. She said *'I used to work with her in my previous life. And um, even though we don't live anywhere near each [other] I would have liked her to have been my kid's Godmother'*. She talked of being *'terrified of seeing her. You don't know, you don't know what to say or anything like that'* but also *'really quite honoured'* and possibly a little guilty when she had been asked to visit. In her telling Beth explicitly acknowledged the different performances that she believed were part of who she was becoming.

¹[pap] Verb: to defecate.

'I think even though it's on a personal level and I know that it's a complet-, you've got a different mask when you're at work, but um I think I handled it better than I would have done had I not been doing this.' (2B7)

Beth told a story of the intersection and interaction between her personal and professional worlds as she sought to reconcile the different relationships with patients and friends. She suggested that *'I still am the most pathetic emotional person ever on the wards when I'm working with people I don't know'* but also that *'I think I was more confident in seeing past the illness I suppose.'* Drawing on her recent hospital experience, she suggested she was *'a lot more in control....but I think I was able to blag my way through it better than I would have been able to normally.'*

Using the word 'blag'², Beth acknowledged her attempts to convince others of the legitimacy of her performance, even when the associated emotions suggested she did not feel legitimate. Her feelings of being *'in control'* and *'a lot more comfortable helping her out with that [using a commode]'* were performed for her friend, her husband and herself. Peña-Talamantes (2013) asserts that in this intersection between worlds, lies the arena for identity negotiation (*'I didn't feel so useless...I mean it is different when it's your own friends isn't it'*). In retelling the story of overcoming her own fears, Beth performed what she viewed as her developing Student Nurse identity; at this point, a veneer of control disguising the anxiety of helplessness.

The ongoing intersection between the personal and professional worlds was the basis for Beth's next, almost confessional recount (2B8). She talked about two patients she had contact with, the first characterised as *'a lovely, lovely bloke'*. By contrast, the second was referred to as a *'horrible, horrible man.'* He was characterised as *'vicious'* and sarcastic, the assumption being that this was not how patients should behave; that he was in control of his actions and responsible. There was evidence of Beth's real distaste for this person because of his behaviour towards her, and how this changed when male staff were present (*'He was such a misogynist....And I disliked this bloke with a passion'*). Beth's challenge came from the fact she believed her personal perspective had no place in how she related to him professionally (*'I still had to treat him with the same level of respect and dignity and*

² blag: to convince by rhetoric; to gain acceptance or approval through persuasive banter or conversation

patience as everyone else. That was a tough thing'). She rationalised her reaction by suggesting 'everyone felt the same about him' but also expressed guilt because 'he was query Alzheimer's' and 'it might not have been his fault' (2B8).

Where she was confident the person was not responsible Beth was more tolerant, even to the point of dismissing a physical assault ('He hit me a couple of times.') because the person 'didn't have clue', 'I don't think he meant malice by it'. She set herself apart from those who, when hit, shouted at the person suggesting 'I couldn't see the point...he looked almost a bit panicked and confused himself'. While she was unsure of how to respond, she did not associate with the immediate responses of others ('I kind of laughed a bit really if I'm honest. I don't really know what else to do'). In the act of telling the story, Beth was rehearsing her response to these challenging situations. She was aware that her usual personal reaction was not appropriate, performed her uncertainty, and the ongoing nature of these practical dilemmas.

In a move from apparent uncertainty to agency, Beth's next two bounded stories focused on events where she felt more confident (2B9 & 2B10). The first was principally a self-observation where she was content to contradict herself suggesting she wished to go unnoticed in the classroom whilst at the same time being the mouthpiece for her seminar group. She made an explicit claim about her academic identity but also stressed the significance of the group identity and the fundamental similarities that she shared with others. In doing this, she sought to simultaneously negotiate both uniqueness and similarity.

'I'm not an intellectual. I use unnecessarily big words. I don't intend to. It's just who I am..I feel a bit of a misfit sometimes because I've, I've made myself noticed. I don't like to be noticed. I hate being noticed...I love who they [fellow students] are and what they stand for. I love the support we give each other....we know that we're as green as each other so you don't have to worry about what you don't know.' (2B9)

Applying this to a clinical context, Beth made a statement about her belief that students should be allocated to placements in pairs. She supported this with the story of her own experiences which also served as an opportunity to rehearse her values, contrasting her actions with those of others.

‘when we’re bored rigid, because we’ve got nothing to do and nobody’s directing you and the NAs’ [Nursing Assistants] have gone off skiving or whatever they do; that if there’s another student on the shift you can grab each other....It’s quite nice to have that conversation and work through it together.’ (2B10)

Beth stressed the importance of *‘camaraderie’*; of shared experience and a sense of belonging. Fellow students were presented as learning partners who validated her interpretation of events and her expressed values.

At this point, Beth portrayed her image of nursing in practical and technical terms expressing frustration at times when she felt she was prevented from participating in activities such as medicines administration and cannula removal [plastic tube inserted into a blood vessel for delivery or removal of fluid]. This informed her next story presented in the context of herself and her fellow students as representatives of *‘a new generation of nursing’*.

Beth introduced story 2B11 by briefly discussing *‘crap mentors and good mentors’*. She expressed an affinity with recently graduated nurses who create *‘the good experiences’* by *‘the more they let you do’*, *‘the more they expose you to’* and *‘the more they stand up for you’*. Enacting the early stages of legitimate peripheral participation, Beth established a distinction between the *‘old-timers or the nurse auxiliaries’* and *‘a new generation of nursing’*. She then made an explicit, future-orientated identity claim by stating *‘I do think I’ll be a good nurse’*. She offered as her justification for this, the reputation of the university and observed practices of recent graduates. Beth’s logic was clearly *‘if I do what others have done, I will be the same as them.’*

Her agency is drawn from how she saw herself as a student, performed in this context as being ambitious, dedicated and willing to take risks.

‘I..I put a lot of pressure on myself to-. I have to keep reminding myself I’ve just started. I’m my own worst enemy. I self-doubt. And, um, I always feel as though I should know more than I do and I get frustrated by that.’ (2B11)

This frustration and mild indignation emerged regularly in Beth’s stories and represented the tensions between her desired and actual clinical role, the perceived slow pace at which

she was being *'taught'* and uncertainties that she could continue to justify the costs of her participation in the programme.

Beth ended the meeting with disclosures that inform the tensions initially revealed in 2B11 and which appeared to exist at both practical and philosophical levels.

'I can't just do something for the love of doing it. I have to know where I'm going to next...to progress and to progress well. You should never do a job with your eye on the next job. You should always do what you're doing now to the best of your ability.....I just have to know that this isn't just always going to be it.....I'm making a sacrifice for the family and because of my age, I've got to get it right at some point...And he [Beth's husband] said to me that he's never see anything grab me quite as much as this does....But I did say to him, I could get to the end of this and think, do you know, this just isn't right.'

She was rehearsing her uncertainties and performing competing role identities. This section effectively illustrates how people can hold contradictions in very close proximity as they form and reform their identities.

Meeting in Month 8 (Nearing year's end)

Beth began our final meeting with a significant statement that had seemed prepared or rehearsed and which set the scene for the anecdotes that followed.

'...I don't want to work on the wards. Erm, I think it has the potential to be a reasonable job, but as it stands, I don't believe that it is. I think that even though they're trying to change the face and reputation and the qualification behind nurses, I think the reality is that it's repetitive, restrictive, hierarchical, erm and there is very little thinking, erm, required or facilitated, I think, within the role.'

The frustration expressed during our previous meetings signalled tensions between anticipated and actual experiences. The stories Beth chose to tell suggested that, in the intervening 3 months, rather than diminishing, these tensions had increased. Her first account contrasted her personal identity with how she was viewed by others and was a story of conflict.

In 3B13 Beth recalled approaching a ward manager to make a suggestion about how to improve the serving of meals. Having spoken to the Housekeeping staff she concluded that the process could be completed more efficiently. In Beth's telling, the senior sister was presented as someone resentful of criticism and not receptive to suggestions (*'stone-faced'*). She was the antagonist who represented the system and culture as well as the overseer of a *'rubbish'* ward. The newly qualified staff were positioned as *'poor'* powerless individuals in a hierarchical system.

Her frustration stemmed from her failure to effect change despite her perceived attempts to address the issue sensitively (*'I tried so hard not to posit it as a criticism'*). She expressed her position in the hierarchy with her use of emotive language suggesting the ward manager *'snapped at me'* and the reaction *'was just a complete slap down'* (3B13). As in 2B11, there was evidence of affinity with the newly qualified staff rather than *'the registered nurses [who] bitch and complain about them so much, they get no support.'* Beth returned to this story at a later point providing much of the detail as well as her evaluation of this event. It appeared she was enacting her disillusionment and disrespect for those who perpetuated a culture that she interpreted as *'so petty, bitchy and political'* concluding *'I think it's just a dreadful environment. I think it's truly broken'* (3B13).

After such a damning assessment of her experiences, Beth then explicitly located herself as an outsider, a situation about which she seemed ambivalent and, to a certain extent, inevitable. At this point she made a significant disclosure to herself and to me by suggesting *'I don't feel as though I fit in.'*

'I've found this in every industry that I've ever gone into, where I'm the newbie.

People don't appreciate you asking too many questions. I think people don't like you treading into their territory because they feel threatened.' (3B14)

Fitting in and achieving a sense of belonging are seen as the products of secure and meaningful social bonds (Malouf & West, 2011) which in turn contribute to a person's identity (Walker et al, 2014), their degree of workplace satisfaction and ultimately affect retention (Cowin et al., 2008).

While she was clearly frustrated by the attitudes and behaviours of some nurses, she quickly asserted *'I get on with the patients really well. The patients and their families give me lots of*

really lovely feedback' (3B14). In the same story, she also restated her claim as a philomath, an aspect of herself about which she seemed most secure.

'And, as I've said on many times, I have a thirst for knowledge. I love it.'

Where there was a crisis in relation to associating with a group identity, Beth emphasised other threads of her developing identity but also questioned her suitability.

'Well maybe I'm just not, I'm not fit for this and maybe this isn't my bag...I just don't really feel it.' (3B14)

The significance of this story appeared to lie in the contrast between how she felt and how others saw her. From her husband's perspective *'I come back from every class or shift absolutely buzzing with something that I've come across on a particular day or something that I've learnt....he's never seen me as fired up about anything else.'* However, Beth suggested that *'I don't think it [nursing] requires much thinking, much on the spot evaluation and going anywhere, other than on a very rudimentary level'* and, as a result, she felt *'despondent'* and was *'struggling to see where I fit in.'*

Story 3B15 concerned powerlessness as a Student Nurse in a clinical environment and Beth drew on two instances, one a conversation between herself and a lecturer, the other the reporting of an incident experienced by a fellow student. Both were stories involving feedback to those in positions of power, namely hospital managers and mentors. She concluded *'Oh my gosh, if this is where constructive feedback is going to take you.....is it a good career move for me to then go to the chief nurse with a bunch of suggestions?'* (3B15)

'I've heard a lot of people complain as well that they, they just don't like comments.'
(3B15)

In the wider context, this story contained elements of the whistle-blower's dilemma and the trade-off between perceptions of loyalty and fairness (Jackson et al., 2010; Waytz et al., 2013). Interestingly, her sense of loyalty appeared to be directed towards the service rather than patients or the profession.

'I know that the hospital could work so much more efficiently with just those few minor tweaks. I know it could.'

Beth's emphasis communicated her certainty, even with limited experience, but also served to provide a basis for performing her passion and desire for quality despite feeling

disempowered. The telling of this story created a reflective space where Beth both performed her identity claims and revealed some of her impressions about nursing and the health care environment.

'there is so much box ticking and being seen to be doing the right things, that what really matters is gets missed. And I'm not saying that nurses don't care about the patients...but it's certainly not what you'd imagine it to be.'

Her use of the second-person personal pronoun might suggest a shift from an individual 'outsider' perspective to one that is more generic and accommodated Beth's status as part of the collective, even at this very early stage in her career.

In the next few stories, Beth told of events that had the potential to become transformative or what Benner et al. (2010, p14) refer to as a *paradigm case*. These are strong instances that impact the past, present and future understanding of events and which experts are understood to use as situational markers to guide practice (Benner, 1984). These are often exemplary but can also be critical or confessional as was 3B16 (James, 1996).

Beth told of three instances where she made assumptions about the care needs of patients which turned out to be incorrect. The principal experience concerned her holding the hand of a person during an intimate and invasive clinical procedure being conducted by a doctor. A neurological condition meant the person was unable to communicate verbally and had very restricted physical movement. Beth admitted *'I felt her moving but just assumed it was like the involuntary movement, and I kept hold of her hand. And then, after a while I felt her hand, it's almost like she gave every effort she could to pull her hand away.'* In the reflection that followed, Beth performed her embarrassment and her sense of rejection.

'I was uncomfortable because I felt as though she was really annoyed by me....I'd assumed she wanted some support', 'It's wrong to assume', 'I'm very angry with myself.' (3B16)

In her telling, Beth adopted a style and lexicon that is common in clinical practice moving from person to patient focussed language (*'you just get your DNR's pretty much and your diabetics'*). The scene was set with an emphasis on the procedure (insertion of a rectal tube) as if this were an everyday occurrence and Beth sought to establish herself as a nurse

through her perceived responsibilities to 'patients'. Initially, the person was presented as someone whom Beth pitied. As the events unfolded, she realised that even with profound disabilities, this person still had the means to make herself and her wishes understood, rejecting Beth's support and her reason for being involved. It was the apparent challenge to an assumption Beth had about herself and her role, meaning and purpose that resulted in her feelings of embarrassment. It was these emotions that appeared to make this a memorable and previously repeated story. Pals (2006) suggests that stories with high emotional content are often indicative of exploratory narrative processing where the teller reflects on an experience with *'an openness to learning from it and incorporating a sense of change into the life story'* and achieve an elaborated self-understanding (p1081). These have the potential to become key narratives, stories rehearsed and *'polished'* ultimately becoming *'personal and symbolic marks'* (Boenisch-Brednich, 2002).

Emotion formed a significant part of Beth's next story when she began to cry whilst recalling an incident. Beth witnessed a surgeon's post-operative examination that caused a person pain but where she did not feel able to intervene. In setting the scene, Beth made use of technical language to signal her professional legitimacy (*'he'd had it stapled and it had dehiscd'* 3B17). She expressed her disdain for the perpetrator of what she considered as unacceptable care with a dismissive reference to the medical hierarchy (*'the surgeon, doctor, whatever he is...'*). Beth used this story to illustrate her clear positioning stance as a prelude to admitting her trouble in aligning herself with nurses.

'I often find myself in a [laugh] an, us and them, against the staff and with the patients.' (3B17)

The expressed reason for this was that for many staff, *'it's just walking egos and [they] bitch about other staff because they're better nurses than they are'*. In spite of this challenging context, Beth adopts a collective pronoun including herself, and me as a nurse, in her global assessment emphasising *'It's all just bravado and yes, I just, I just, I just don't think we do right'* (3B17).

Coda

Over the course of our meetings, Beth was explicit about using the opportunity to share her stories, views and opinions as a means of ordering and making sense of experiences. Her academic, personal and professional histories were used to validate her decision to become a nurse, not only to others but also to herself. Her initial motivation was the excitement and novelty of becoming something different. Her stated admiration for nursing and nurse' actions clearly did not have a basis in first-hand experience. Rather she seemed embarrassed by the admission that she had initially believed nursing was what someone did if they lacked intellectual capacity.

As Beth accumulated experiences and developed these into stories, she represented an increasing affinity with her fellow nursing students and the people she cared for but not those with whom she worked in clinical practice. She emphasised distinctions rather than affiliations and became frustrated by the bureaucratic and obstructive systems she perceived the staff were complicit in maintaining. Beth appeared to struggle with the contrast between how she interpreted her experiences for herself and the impression her family and others reflected back to her.

More than any other participant, Beth explicitly acknowledged that she used the meetings as a forum to express her views and opinions. These addressed views about the organisation of the Health Service, the profession and some of the people she had worked with, the apocryphal notion that learning only really starts once a student qualifies, and the dissonance between classroom 'best-practice' and clinical 'real-world' practice.

Postscript

A number of months after drafting this chapter, I discovered that Beth had withdrawn from the programme soon after the data gathering period had ended. Importantly, I was not aware of this as I re-storied Beth's accounts and attempted to understand how she developed her professional identity.

I am not privy to the exact reasons behind Beth's decision to leave the programme. Re-reading her stories, they take on new meaning. Dissatisfaction and dissonance, a tendency to cast herself as an outsider and her reluctance to associate with the profession might all suggest an inevitability about her ultimate decision. Any narrative analysis and interpretation is retrospective, conducted after the story has been told, making the context a crucial element of the co-construction (Kvernbekk, 2013). I am acutely aware that, had I known of Beth's decision before conducting the analysis, each story would likely have been contextualised very differently. In the act of establishing connections, causes and effects, it is conceivable that Beth's stories would be interpreted as steps on her path to discontinuation. What this serves to reinforce is that narratives, and our interpretations of them, are always temporarily and contextually situated. This does not render them false, simply part of an ongoing, broader life story.

Chapter 6 - Denise

Introducing Denise

After our initial meeting in October 2015, Denise would arrive at subsequent meetings wearing her fitness clothing and carrying a sports bottle. She gave the impression of being busy; trying to pack a great deal into her day. Denise gave the impression of relishing being ‘on the go’ whilst also valuing the times where she could slow down, focus and tell her story. During the course of our three meetings Denise told 27 bounded stories representing each of the four genres discussed in the Methodology. In addition, she also recorded three audio diary entries between our scheduled meetings.

Denise, like Beth, was 43 years old. According to her responses to the demographics questionnaire she was ‘switching careers’ but in her initial stories, the plotline suggested a reconnection with her past. At 18 years-old Denise was working in a Nursing Home. She did this for a year and a half before the birth of her eldest son. She returned to work but found that, because of his behavioural and learning difficulties, she had to make the choice to stop and bring up her four children. She worked part-time and close to home in various jobs, including a long period at a supermarket. In 2011 she made the conscious decision to change the direction of her life and took another job in healthcare, prompted by the advice of her mother just before she died (1D1).

‘I changed my job completely, so it was like a bit wild. I changed my, erm, (hh) complete routine, which is unusual for me because I like routines....So I got a job in healthcare, private healthcare again, part-time, so I knew that would kind of support my, erm, college course....and (.) I just fell straight back into it...it was good that I’ve come back because that’s definitely where my forte is because I really enjoy it and it’s rewarding’ (1D1).

In her demeanour, language and portrayal, the point at which I met Denise suggested she viewed her undertaking as an exciting new chapter or act in her life-story. In subsequent

stories she enacts her own re-invention, highlighting how she was different to herself in the past whilst retaining what she regarded as central to the person she wished to be.

Pre-course personal statement

In the first section of her UCAS statement, written as she neared completion of an Access course, Denise suggested that the pathway from HCA to registered nurse was a '*natural*' progression. Rather than portraying nursing as her destiny, like some others, Denise included the phrase '*careful research*' to illustrate that this was an informed and pragmatic decision. Her stated goal was to '*become a qualified adult nurse*'. Without any reference to possible future career objectives, Denise made clear she was approaching her learning and development on a stepwise fashion. Her use of a journey metaphor suggested she is aware of the transformational nature of the experience she had applied for.

'I know it will be a constant learning curve and understand it will not be easy to succeed but I have the willingness and determination to do so....when I get to university, I am feeling excited about meeting many more interesting people on the road to becoming a registered nurse.'

Like many such supportive applications, Denise claimed personal characteristics that she believed are consistent with nursing practice (Ding, 2007). Motivation, supportiveness, drive, commitment and eagerness might be regarded as identity claims labelled as '*my best qualities*'. These were wrapped into an account of what nurses do designed to illustrate a realistic rather than romantic viewpoint. By mentioning shift-working, responsibilities and 'duties' Denise sought to establish her suitability to become part of the nursing community.

Meeting in Month 1 (Pre-clinical)

Most of the participants responded to the invitation to tell a story about how they came to be on the programme by recounting an abridged life story. In doing so, they selected aspects of their history that represented a coherent pathway and justification. As mentioned above, Denise characterised her journey as a rediscovery. The death of her mother was offered as the critical catalyst to re-evaluating her position and re-engaging

with education having suspended this to bring up her family. The story was one of agency about her willingness to take risks and the early exciting stages of a rediscovered relationship with learning.

'But I thought, No, let's go wild, let's do it, if we're going to do it at all....Well let's just, we'll go to the interview....I might be setting my sights a bit high going to university'. (1D1)

She drew on her recent experiences to illustrate her legitimacy as a committed learner.

'And also, I enjoyed the academic side as well, which I know is quite difficult to, erm, but I just enjoyed the the fact that we had to meet deadlines and do lots of research and reading and the learning... And I thought, you know, This is good!' (1D1)

To emphasise this, she tells in later segments of 1D2, of how she had grown in this regard.

'...actually, now I realise, looking back, that I never tried as hard as I could. It was kind of like sitting back and doing whatever (hh) but going through the motions academically...there wasn't a maturity, but now (.) I feel that it's absolutely right.'
(1D2)

Denise's claim was explicit and reflects the position expressed by many students entering higher education later in life that, without life experience, they were 'not ready' (Waller, 2006). Denise was clearly staking her claim to both being ready and willing to invest herself in the endeavour.

To support this, Denise told the story of a remarkable event that clearly had persuasive value for her and her audience. It was evident in the telling that she had probably recalled this a number of times. The year before, Denise has assisted at a car accident alongside two other people who turned out to be nursing students. Unbeknownst to Denise, her involvement in this incident had been passed to the Admissions Tutor at the university who ended her interview with the comment *'I don't need to ask how you behave in a crisis'* (1D2).

The focus of the telling was not on the desire to help at the accident but the validation and feedback provided by the interviewer. This was evidence that Denise used, for herself and her audiences, of her capability in challenging situations. It was significant because it occurred at a time when Denise was questioning her career choice.

'So I was like, This is the right thing to do, I can manage it. Because I thought, Can I cope in a crisis? And I thought, Actually, yes I can! And it was all a coincidence because I was thinking, Can I?'

Denise's identity claim stemmed from a syllogism about herself and her career choice. 'I can cope in a crisis; nurses have to cope with crises; I can be a nurse'. Evidence of her agency allowed Denise to represent herself to others, and herself, as someone with the capacities she believed were required of a nurse.

This justification of capacities was continued in 1D3. In the preceding stories, Denise authored herself as a legitimate student and the 'right sort of person' to be a nurse. Here she presented herself as a 'good mother' who made necessary sacrifices for her son and was committed to acting as his advocate. In the telling of the story, she communicated the values that she believed make a good nurse without making this an explicit claim. She did, however, rehearse the decision-making process concerning starting the course.

'...you have to really look at it and weigh it up and think, Is this really the right thing to be doing right now? Is it, you know, does it feel right? And if it doesn't feel right, I don't think you should do it' (1D3).

Her portrayal was of someone juxtaposing motherhood and nursing, not explicitly in terms of shared values but in terms of significance and commitment.

Having been asked if there was anyone or anything that influenced how Denise saw herself as a nurse, she told the story of a matron she had contact with in a nursing home (1D4). Like both previous participants, this was a brief tale about 'who she is not' rather than a role model in relation to what it means to be 'professional' (Yuval-Davis, 2006). It was performed as a story of realisation; that initial impressions might have been an 'illusion'. Denise initially positions the matron as 'really professional' and someone that she 'quite admired' but this situation changed because 'she's not what I thought she should be' (1D4). The prompt for this reassessment was that 'she wasn't following the procedures that she should be following', her evaluation confirmed by triangulating with other members of staff. The matron was represented as powerful and responsible in this situation. Denise portrayed herself as dismayed and disappointed by the experience and unable to challenge what she witnessed.

While there are references to the rule-bound nature of early professional practice in 1D5, this story also emphasised the self-authoring that results from third-party practice. Day et al. (2005, p642) claims *'Even at [an] early stage, the students began to critically observe registered nurses and to make decisions about whether they wanted to nurse in similar ways'*. Along with other stories during our first meeting, Denise represented herself as someone who was not naive or likely to be overawed by first impressions. In doing so, she challenged the assumption that novices are rule-driven, adopt concrete thinking approaches, believe and trust authority without question (Claywell, 2014).

The importance of rules and procedures was expanded upon in 1D5, an exemplum told in reverse with the interpretation of the incident expressed early on. Drawing on her time working in a nursing home, this was a historical tale where an unnamed person who did not provide care to the standard that Denise felt was appropriate. By being explicit about her personal values (*'We all know the basics of looking after someone and treating them respectfully..'*) and then her professional and moral responsibilities (*'I said, "Because that's what you should do"'*), Denise made a professional identity claim. Her use of reported first person speech positioned her centrally in a story that conveyed her nervousness and sense of exposure. Much of the story's final sections were about her hope that *'because I've mentioned something, it's made them realise that that's not the right way'*. In this story, Denise created a character of herself as someone whose values informed her actions.

'...because somebody behaved in a manner that I didn't think was correct and so I wasn't going to, obviously let that go. So I (.) confronted that person...' (1D5)

Denise linked her professional self in 1D5 to a view of herself as a person in 1D6 through a detailed recount of the care her mother had received. A documentary programme about standards and abuse in some UK nursing homes had prompted her to increase her scrutiny of the carer's practice. Having worked in a nursing home setting herself, Denise performed her distress as an outraged observer and disbelieving, disappointed carer. In telling the story, Denise distanced herself from the reports by repeating *'I'd never seen anything like that'* as well as performing the impact of what she had seen.

'I saw the thing on telly (.) about the Francis Report and, err, also about that, erm, Oh God! It really upset me. I was like crying'.

The reported events appear to have reminded Denise of her experiences as an 18-year-old and raised her awareness of the responsibilities of the qualified nurse prompting her to question *How could they be so incompetent?*

Denise's final two stories told during our first meeting concerned herself as a learner. In the first (1D7) she began by positioning herself as an inexperienced student who was surprised at her initial successes on an Access course (*'I didn't think I could possibly write an essay like that.'*). The language used was performance of a philomathic identity (a lover of learning) (*'there's so much to learn and I love it.'*) similar to that presented by Beth (1B4 & 3B14). At this early stage, Denise was keen to portray her commitment to both of the new worlds in which she had invested.

'Being a nurse and being academic, I've realised really strongly now, that it is two things that are together and they're good, they're my most favourite things.' (1D7)

There is also an acknowledgement of and a sense of responsibility towards her mother, in much the same way as Andrea expressed (1A1 & 1A4).

'Um, because I didn't throw myself into that side of things [studying] but my mother always said, "You should do it. You'd be really good at it". And I was like, Oh no no...But it surprises me, she was right'. (1D7)

In this type of story, Denise's mother was characterised as the 'wise woman' or guide familiar in numerous contemporary and historical literary plots (Booker, 2004).

Denise ended our first meeting by seeking to establish an association between herself and those teaching her, again in a similar vein to Andrea (2A16).

'Do you know what, they're [tutors] not scary'

Having initially characterised her tutors as different and formidable she told of the realisation that this difference is due to their continued learning, something that she herself has the agency to achieve. She made a clear categorical statement that *'you can't, erm, work in healthcare in any way unless you're... you have to be educated. You can't be uneducated.'* In this statement, she sought to dispel a myth, establish affiliations with teaching staff and emphasise her own commitment to learning as part of nursing practice.

Month 3 (Beginning practice)

In the only audio diary entry between our first and second meeting, Denise recalled one of her early clinical experiences as a nursing student. She had been asked to monitor a person who had previously undergone surgery following a head injury. She presented herself as being '*completely unprepared*' for the situation she faced, and the patient as '*very unpredictable, er quite confused and agitated and anxious*' (D9). The story was driven by the emotional energy of fear as well as the desire to be seen to be coping. The message in the story was 'I was thrown in at the deep end, not adequately prepared, but that I dealt with it' and is similar to the accounts of many newly registered staff (Draper et al., 2010).

'It was an eye-opener and I understand now what it's like to work with people with head injuries.' (D9)

These 'in at the deep end' stories are commonly told by nurses to illustrate the rite of passage (Andrew et al., 2009; Levett-Jones & Lathlean, 2008) and establish their legitimacy to belong. An important additional identity claim is made in how these situations are managed. Retold 'sink or swim' stories are typically about success.

'I mean, I did handle the situation quite well!' (D9)

The story became evidence of Denise's abilities as well as a token or artefact she could use to legitimise her sense of self as a nurse.

Meeting in Month 5 (Returning to university)

Denise began our second meeting with a recount that she believes represented more than a simple shared experience ('*it's sort of quite universal for students to feel that way*' 2D10). It concerned the nature of supernumerary status students have in clinical practice situations. Originally intended to shift the student's status from worker to learner, supernumerary status has proved a source of confusion for students, mentors and ward managers in terms of expectations and level of involvement in clinical practice (McGowan, 2006). In the early stages of a programme, the result is role confusion between students and health care assistants, especially for those who are transitioning from the latter to the former (Brennan & McSherry, 2007).

Tasked by her mentor with conducting regular observations of a person returning from surgery, Denise found she was pressured by the matron to leave the ward and go to the Radiography Department. At the same time, an HCA was asking for Denise's assistance prompting her to comment that *'you cannot be in three places at the same time [laugh], it's impossible'*. Without the direct support of her mentor, Denise felt *'there was nothing I could do'* and *'like you're a child in like a parent environment'* (2D10). The effects of role confusion and powerlessness created a crisis for Denise, a situation that was exacerbated by the apparent dissonance between practice values taught in the university and the realities in the clinical setting.

'...what you read in the books isn't exactly what goes on in practice...So the person-centred care they teach here, it's so disappointing to see that it's not put into practice. Sometimes it is, you see little fleeting moments of it, but it doesn't last long when audits come along...' (2D10)

Denise managed this crisis and her own identity by establishing a generational distinction in the same way as Beth (2B11).

'they've got all their priorities in the wrong place and it's really old fashioned nursing. What I see is still old-fashioned.' (2D10)

She suggested that the situation would improve when *'the nurses that are being taught now or two years ago, three years ago, drip into the Health Service'* (2D10).

In telling the story Denise recalled a comment by one established staff member who predicted that *'You'll [Denise] just end up like everyone else'*. This appeared to cause her a sense of anxiety. In her performance, she represented herself as a rule-follower working hard to resolve the conflict with the culture she was being asked to operate in.

In order to underpin her own identity claim, Denise told one of the few stories amongst all the collected data, of what she felt was exemplary practice. She recalled an incident involving her mentor, whom she regarded as *'very good'* and *'the most compassionate person'* because *'she took time out of her routine because she wanted to make sure she [the patient] had the best treatment'* (2D12). The nurse was characterised as someone who *'hadn't lost'* the ability to care, a lone example of what Denise felt *'it's meant to be like'* and someone who *'Sticks to how they should behave, how they should treat people'*. Rather than being presented as a typical role model, the foregrounding of good practice provided Denise

with the opportunity to rehearse her own identity with evidence that her stated values are professionally congruent. Having made this case based on observed practice, she then tells a narrative account of her own (2D13).

Using two instances, Denise explained how she came to realise that her automatic, personal reaction to a situation might not be in the best interests of the person she was caring for. *'I learnt to control myself; control my facial features so that the patient would be reassured'* (2D13). In the telling Denise performed her ability to be compassionate, a key identity marker, that is notoriously difficult to define (Bramley & Matiti, 2014). She also made explicit the distinction between her relationship with patients as a person and as a nurse. Dowling (2005) suggests that *'Nurses often undergo an unofficial socialisation process where it is considered unprofessional to become too close to patients'* (p50). In this story Denise sought to establish the distinction between 'too close' and 'empathic', another potential identity marker.

She positioned the patient in this story as needing protection from the truth or the full extent of their situation. Conscious that her reaction was being monitored, she needed to respond to the immediate situation based on *'common sense'*.

'She was like looking at me and I knew she was looking at me to see what, when I looked at the wound, to see what I looked like.....that moment mattered.' (2D13)

In the story Denise described taking on a character that required her to operate between the competing values of compassion and honesty. In the telling, she performed her discomfort that she *'lied a bit'* but for justifiable reasons. This minor crisis segues into a more significant crisis that Denise hinted at during 2D12, namely that even good nurses can be changed by the system and the culture.

During a busy shift, Denise was reprimanded for using a hoist on her own to help a person transfer onto the toilet because no-one else was available. She was aware that the protocol stipulated two people were needed to safely operate the hoist but felt unable to convince the ward sister to help her. Her powerlessness in this situation prompted her to comment *'I actually stood in the middle of that corridor and I thought, No, why am I here?'* (2D14).

Posing this existential question in her story, provided Denise with the opportunity to then rehearse her motivations.

'I thought to myself, 'I don't want to be, work in an environment like this...I knew why I wanted to do the job, but I just had no idea it was that stressful and that difficult.'

She continued by performing, through tone and language, an attitude of passive resistance, a refusal to become another part of the system. This was achieved through her statements designed to author an image of herself in the future as someone who will not *'fall into the trap'* and *'end up like an automaton'* but will *'make a difference'*.

'But as you, the career gains momentum, I think you can make a difference. As long as you remember, always, why you want to make a difference, what it's for.' (2D14)

This self-delivered pep talk encouraged and demonstrated commitment and dynamism in the face of a challenging situation and where she perceived herself to have limited power.

Establishing previously untapped sources of power is the focus of 2D15 as Denise recalled how she managed a care situation involving a person with dementia and an HCA. Denise tackled the HCA for removing the patient's breakfast without establishing if they were receiving adequate nutrition. She was told that the HCA had more experience and the issue was dismissed. Rather than perpetuate a direct confrontation, Denise told of how she wrote and posted an anonymous article about the importance of nutrition for older people with dementia. Her identity claim was associated with her actions, namely that she used the power of the knowledge where she lacked positional power.

Again, she made explicit statements of difference before questioning the suitability of some people for care roles.

'I've never worked like that. That's not something that I do...That's not normal...I don't think they've got the qualities on an emotional level to deal with someone that's a patient in hospital.' (2D15)

She aligned herself with a new generation of nurses (*'some of the people that I'm studying with now, can make a difference'*) and presented a picture of a future that better fits her view of nursing. The limited research that exists suggests professional values in nursing are remarkably consistent across generations (students, new graduates, seasoned professionals) (LeDuc & Kotzer, 2009) but it is how nurses view each other that has a

significant impact on their functioning (Wolff et al., 2010). Current staff operated in and represented a culture that Denise wished to resist and she performed her professional identity through stories that articulated this subtle resistance.

In the university setting this resistance was not necessary because, *'it feels like a safe place to come and talk among yourselves, you know, and understand that you're not alone'* (2D16). Denise told of sharing her initial ward experiences with others and achieving some reassurance from the fact that many were shared and that her own interpretation was not unusual. Classmates were positioned as confidants with shared values and a sense of camaraderie (See 2B11).

'Oh my god, is anyone else going through this?...are you right in thinking the way you're thinking about things? And then you are with like-minded people...you get reassured that, No, other people are going through similar.' (2D16)

The university context was characterised as *'safe'* and a venue for Denise to author herself as a transformative agent, challenging the perceived status quo.

'You have to really pull yourself up together and go, Right, you can do, you can make a difference in some way. In fact, I believe that I did to some people that were in there.' (2D16)

She presented herself as the embodiment of *'this new system, you know, person-centred care is the thing'* encouraged in the classroom but not always perceived in practice.

Moving to consider herself as a learner, Denise suggested *'I don't think I've changed that much really...I don't feel too much different to what I was before I went on placement as a student I suppose'* (2D16). She goes on to articulate what she perceived to be the characteristics of a good student (keen to learn, respectful of the subject, aware of the complexities). Her comfortable articulation suggested that she does not view the academic environment as challenging in the same way as practice. In the academic setting, she was part of a cohort with a strong sense of belonging while in practice she portrays herself as part of *'this new system'*. In 2D18 Denise employed metaphors and images to cement this assessment. As a group, she likens herself and her colleagues to *'little baby birds'* that are trying to *'feel our way through the jungle'*. The underpinning narrative was that the group were *'growing together'* and establishing strength in their unity.

Denise's final stories at the midway point in the year (2D17 & 2D18) were used to emphasise this unity and her role as a champion for younger students. When told by a staff nurse that any problems should be taken to the ward team and not the university, Denise interpreted this as '*a bullying thing*' that '*really ruffled my feathers*' (2D17). She presented herself as defiant and unwilling to collude suggesting '*We've been trained before we came here about safeguarding issues*'. This story provided Denise with the opportunity to perform her indignation and courageousness as well as demonstrate for herself and others her awareness of right and wrong. She acknowledged that being '*a nurse is, you know, a lot more emotional than I dreamed it would be*'. She concluded the meeting with the admission that '*I think I have changed a little bit as a person but I'm not quite sure how...I think that's the trouble, people forget who they were because they slowly become something else*' (2D18).

Story D19 is unique, being told as an audio diary entry during a block of university study. Denise reflected on a session concerning assessment-informed discharge decision-making and draws on her own practice.

'there was a lot of pressure on the health care professionals that were in charge of the discharges to get as many discharged as possible because there were so many waiting to come in into the beds.' (D19).

Denise was explicitly contrasting the expectations of lecturers with what she saw happening in practice. By commenting, '*But that's not a realistic way of looking at it*' suggests she was focused on the practicalities of the clinical environment rather than the professional responsibilities that the lecturer might be attempting to communicate. The '*pressure*' in the practice environment seemed to have a greater significance for Denise, in this situation, than the pressure of expectation from the lecturer. She questioned the vision being presented within university based on her own experience and seems troubled by the apparent competing expectations.

'Because we were told today [by the lecturer] that, you know, you have to stand your ground but if you're a staff nurse and you want to stand your ground against the ward manager, I think that you could find that fairly difficult...you just have to learn to stand up for yourself and for what you believe is right. But that's not a realistic way of looking at it...' (D19)

Denise was presenting the often reported dilemma faced by nursing students (Pearcey & Draper, 2008), an example of the *'complicated nexus between policy, ideology and practice'* (Stronach et al., 2002, p109). She conveyed her sense of feeling overwhelmed and inadequate in the face of competing expectations. Forde et al. (2006) suggest that *'professional identity is negotiated within situations where identity is affected by dilemmas and difficulties that are often outside the control of the individual'* (p11). However, this situation was not resolved. Denise suggested *'it's just something that's been brought up today and I thought that I'd relay it'*. In doing so she characterised the situation as invidious and herself as conflicted.

Month 6 (Second placement)

Unlike the other audio diary entries, D20 was told about an event that Denise experienced *'a couple of weeks ago'*. It was well organised temporally suggesting previous recounts had helped to shape it and achieve exploratory narrative processing. The incident involved Denise's discovery of a person who was semi-conscious and her actions to raise the alarm. She presented herself as observant, appropriate and obedient in a story that acted as a vehicle for articulating how Denise believed she had changed. She disclosed her physical reaction at the time of the incident (*'my heart was going a million miles an hour'*) and her satisfaction and surprise that she was able to perform a professional persona (*'I didn't show it to anyone else. It was just sort of all inside'*). Her identity claim was that she functioned differently to how she might have expected, using this incident as evidence of her own progression.

'I was really shocked at the fact that I could behave like that. I never thought I could do that and remain so calm.' (D20)

In the latter part of the story, Denise chastised herself for not having responded to the warnings of other patients about this person's condition (*'I was quite dismissive. I shouldn't think like that really'*). This admission, a few weeks after the event, suggested she had overcome the embarrassment and identified the learning potential in the situation.

'So before I would have thought No, I don't want to wake them up, but really, on a clinical, the clinical side of things, you do have to make sure these guys are OK.' (D20)

Denise ended with a commitment to reflection as a tool for both meaning-making and self-knowledge (Mann et al., 2009) as well as presenting an image of her future self as a more humble and attentive practitioner.

Meeting in Month 8 (Nearing year's end)

At our final meeting, Denise preluded the stories she told by declaring that *'even though I am forty-three, I've done a lot of maturing'* and *'I don't feel the same person that I was back when I started.'* She perceived this to have been a *'gradual process'* suggesting she was more patient and perceptive.

Illustrating this change, she told of an incident where, assuming her mentor had forgotten key information during a handover, Denise had interjected but caused confusion. In the discussion that followed, Denise was able to reflect on how she had behaved, the nature of her relationship with her mentor and her notions of *'being professional'*. She positioned her mentor as supportive and understanding even though she had reprimanded Denise for the interruption.

'I should have waited and respected her. And I'm not a disrespectful person.' (3D21)

In her telling, Denise highlighted the importance of mutual respect in the relationship and the sense that she was important and valued as a learner who would make occasional mistakes but had a place within the team (Eller et al., 2014). She interpreted and performed *'being professional'*, in part, as accepting constructive criticism in the context of mutual respect.

'But do you know what, you have to respect people and you have to give them respect and they give you respect.'

She reported elements of the mentor's feedback that were clearly important to her because they served to link Denise's sense of herself as a first-year student and what she hoped to become in the future.

'And she talked to me after and she said, erm, she said, "I was like you once". She said, "But you've to like to sit back and be patient and then you can, you know?"'
(3D21)

Denise told the story as a realisation of how she was maturing and finding *'a certain place so that you can function well as a team'*. Just as important seemed to be her claim that she understood the importance of *'different strategies around problems'* enabling her to be more discerning.

'I thought I was quite an activist when I started this course...and I still am but, you know, you have to take care, be careful and work things differently. You can't just go around waving your banner and going [laugh] because that's not going to get anywhere.' (3D21)

She made the explicit claim that *'I wasn't like that before and I'm not sure when that happened or how that happened'*. Throughout the story, Denise emphasised a view of herself as different but not fundamentally so. She sought to characterise this as *'a way of growing'* and fitting in without compromising the core of who she was.

Denise's apparent contentment with her student status in 3D21 was contrasted with her concerns about the future, told through 3D22 and 3D23. Both stories concerned authoring her future self and included identity claims as she approached the end of her first year. In 3D22 she recalled a conversation with a tutor, who she admires, during a clinical skills session run at the university (*'there's some good teachers here'*). The relationship was presented as one where open discussion is comfortable but there is also scope for challenge as they discussed where Denise might work in the future. She indicated *'I'll tell you one thing I have decided [laugh] already, I won't be working in a ward environment when I qualify.'* The response from the tutor is told as his reported speech.

'He said, you know, "Be in a ward environment because you're really good at, you know, sorting things out", blah, blah'

This constructive feedback from someone who she respects informed her identity in a similar way the mentor feedback in 3D21. She partially claimed this assessment but quickly qualified it in terms of what she felt was realistic for a newly registered nurse.

'I said, "Yes". I said, "But there's not enough protection for people". And I said, "And you can be ostracised". And I said, "And I don't want to be like that at the start of my career, I want to be safe."' (3D21)

To emphasise this image Denise reused a metaphor employed in 2D18 (*'baby birds'*).

'You can't go in as a fledgeling because they don't treat you how you should be treated.' (3D21)

Denise performed her identity as someone who can identify poor practice but did not believe being newly-registered would position her to tackle this because of the cultures that exist in ward environments.

'It's just too, it's too cliché and there's a lot of bad practice that I've seen that I don't agree with. And I don't see myself as being able to change things right at the beginning of my career.' (3D21)

Denise saw her future self as an outsider at the point of registration, not as an individual, but as a representative of a group who wants the system to be different. The story, along with 3D23, exemplified the concerns that many students have (Newton et al., 2009) and which many newly-registered nurses experience (Duchscher, 2009; O'Shea & Kelly, 2007).

In her exemplum (3D23), Denise portrayed herself as a critic of those who, she believed, fail to challenge poor practice in newly-qualified staff in the first instance.

'And they really should address it because sometimes you need to be taken to one side and say, Hey, you know, you've got to really concentrate on this medication round...If I qualified and made the same mistake two times in one week, I wouldn't be ashamed to have a refresher on something'

In the telling Denise performed astonishment and surprise at the situation and how it was handled. For her, *'that's not supporting somebody that's just qualified'*. It was represented as a dereliction. Denise presented herself as someone who expected her competence to be monitored by others in the future. Having previously storied the events that resulted in her own reprimand being handled in a constructive manner, Denise had integrated this into her own professional identity. She was aware that similar situations can be humiliating but suggested she has little tolerance for *'incompetence'* (3D23).

At points in our meetings, Denise articulated her persona as an antagonist with the desire to challenge and change situations (3D23, 2D17, 2D15). However, in 3D24 she adopted a position of reluctant acceptance and expressed a sense of inevitability at her role in her current placement. In contrast to a trauma unit, described as *'a really exciting placement'*, she characterised a rehabilitation setting as *'very boring for me...I don't find it very*

stimulating...In fact, I don't like it at all but there you go [laugh]'. The reason offered for this assessment was that she was being given mundane and repetitive tasks to complete because *'it gives them [regular ward staff] time to do other stuff'* (3D24).

'Fifty percent of it is, erm, filling stuff in on the computer and because, obviously, we're students, we get given that job.'

Her use of the plural personal pronoun suggested she saw this as the reality for all student nurses because of their position in the clinical team. By quantifying the amount of time dedicated to this Denise commented on how disproportionate she felt this is.

In her telling, Denise claimed this is *'the same old story'*, that *'the students are there to do that, so that's cool.'* Her portrayal suggested she viewed this as a 'rite of passage' and an experience that has to be endured rather than actively engaged with. At this point, she did not view these activities as active contributors to her future role or sense of professional identity.

At the start of our final meeting (3D21), Denise acknowledged that she had changed but was not explicit about what had caused this. In 3D25 she established very clear causation for adaptations in her own views about health and shock at the apparent paradox she had come to recognise.

'...seeing people struggle with their weight, really made me realise that I needed to get healthy.'

Focusing on her studies was offered as the reason she had gained weight because *'you tend to lose sight of your health'* (3D25). Exposure to people living with the consequences of poor health prompted Denise to re-evaluate her own lifestyle. She suggested that the trigger for this was a realisation that the clinical environment can actually be very unhealthy.

'I suppose it was just seeing all the really bad food [brought into the ward]. They bring in biscuits and cakes and chocolates, which is, and it's like a ritual, like patients giving the nurses chocolates.' (3D25)

This story provided Denise with evidence of her own agency; the ability *'to affect change in their [her] own live[s]'* (McAdams & McLean, 2013, p234). In recalling the story as a conversation with herself, she was explicitly positioning herself to herself as someone who

has capacity and control in this aspect of her life (*'And when I put my mind to it, I normally succeed [laugh]'*). She continued to attribute this control to other aspects of her endeavour.

'Because since I've lost weight, I've been able to, my academic work, I think, is much better. It's really improved. I'm more alert and I'm not so tired.' (3D25)

In this story, Denise established her association between health, weight, academic achievement and her sense of what it is to be a nurse. Telling the story enabled her to reinforce her successes and triumph over what she perceived to be negative and incompatible. While it was a short story, it represented perceptible evidence of her own self-efficacy and was told with personal satisfaction (*'So [laugh], there we are'*).

The final stories Denise told concerned herself in the university context and how she positioned herself in relation to her colleagues on the programme. She repeatedly labelled herself as *'average'* and suggested that *'they all [her fellow students] think I'm a bit of a geek'* (3D26). This was within an anecdote about her recent assessment successes and her communion with certain topics being studied.

'So, obviously, I got a hundred percent in that because I love it.'

Similar to Beth, there was a commitment to the act of learning which Denise stressed as she recalled her assessment grades.

'I love research and I love reading academic things and learning stuff'

She occupied a position of caution in relation to other subjects where she was less confident suggesting *'they say I write well but don't include enough content'* and *'when I get like probably a really rubbish mark [laugh] in this biology, they'll be like, Oh my god, but hey ho [laugh]'* (3D26).

In the telling, Denise appeared to be experiencing a tension between how she was seen by others and how she saw herself. She wished to celebrate her successes but not be seen as finding the course easier than others.

'And I do find that [biological details] really hard to remember, so, but I suppose I'm not the only one that does. But I think I'm kind of average. I'm average really.'

Denise sought to reinforce the view of herself as a successful mature student in 3D27.

Having repeatedly described herself as an *'average'* student she went on to suggest she had

a significant personal investment in her success and was willing to forgo the stereotypical student practices (*'a lot of the times they go to the pub here at lunchtimes'*) in order to achieve her goal.

'I'm going to have to work quite hard to get a really good pass. So, and basically, that's really important to me, to do academically well.' (3D27)

Her student identity was aligned with other mature students who were willing to be labelled as *'boring'*. As in 2D16, she performed the characteristics of the 'good student' and articulated her dedication to learning and achieving success.

Instances of failure are portrayed as a source of annoyance and irritation rather than a fundamental challenge to her student identity. Denise recalled how she forgot to add the date and time to an observation document during a practice assessment and subsequently failed.

'I was very annoyed with myself for failing that. Because I thought, I knew to do that but I had to take a six-minute resit, to resit the documentation.' (3D27)

She then performed, using her own dialogue, her thoughts about the incident before concluding that *'maybe I didn't think enough of it'* and taking responsibility for the outcome. She did, however, qualify this in her evaluation of the assessment method, an Objective Structured Clinical Examination (OSCE). Her annoyance stemmed from the 'artificial' nature of the situation (Muldoon et al., 2014). Denise sought to separate herself in the assessment environment from the clinical environment stating *'when I'm in the ward I'm quite meticulous with things'* and *'I don't ever doubt myself with things like that, you know, with documentation or the way I am with patients'*. These final comments provide Denise with the opportunity once again to author herself as different in the two worlds in which she is operating.

Coda

Over the course of our meetings Denise recounted numerous stories, the vast majority of which related to clinical practice. Her contrasting experiences provided opportunities for her to articulate the values she associated with nursing, establish a distinction between herself, many of the HCAs and senior nurses she came across and an affinity with newly qualified staff. In the latter meetings, she performed a professional perspective that suggested a

reluctant acceptance of some of the systems and cultures within the clinical environment but retention of ideals that formed the basis of her professional self-concept. Practice is characterised as a conflicted environment for the Student Nurse. The university context provided scholarly challenges but within a philosophical framework that Denise found cognisant and surrounded by colleagues who had concurrent and analogous experiences.

Chapter 7 - Helen

Introducing Helen

In terms of her demographic details, Helen shared many similarities with Beth. They were both in their forties with similar family situations and both were looking for a change in careers having established themselves in non-nursing fields during their 20s and 30s. They became friends over the course of the first year and volunteered to participate in the research together. They both referred to the other at points throughout their storytelling but represented themselves as unique individuals with diverse experiences whose life journeys intersected for a while.

Helen was a comfortable storyteller who responded to the opportunity and setting by flowing from one experience to the next with little input from me. Many of her 18 bounded stories were extended and iterative anecdotes or recounts. At the end of our first meeting, she asked *'will it be quite, erm, penetrating, consideration about yourself and your motivation about how you get here?'* This interpretation was derived from my questions that consciously and consistently asked if she could *'tell me a story'* allowing Helen to control the level of introspection, self-exposure and, therefore, any potential vulnerability. I found Helen's honesty and candour surprising at times, largely based upon my own assumptions about what participants would reveal to a relative stranger. I came to interpret this as a measure of success in creating a secure atmosphere where Helen could tell her stories to me and herself. At the end of our final meeting, Helen asked *'Don't you feel like a counsellor doing this Dan?'* suggesting she might, at some level, have interpreted our interaction, or more likely her own stories, as therapeutic, a point discussed in Chapter 9 (Trahar, 2009).

Helen presented herself as a pragmatic person who was accumulating a 'toolkit' of skills and knowledge rather than realising a lifelong ambition. It is difficult to establish the extent of this motivation in the wider population of nursing students as it is not evident in other research findings. She had prior work experience in commercial industry before life events,

which she storied in passing, prompted a shift to a local government role and a greater sense of stability. Achieving a senior position after nearly twenty years, Helen felt disillusioned and began to explore health-related, but initially non-nursing jobs whilst she also took on a part-time social care role. From the very beginning of our contact, she was explicit that the course represented a means to an end. Already having a degree in English, her focus was on *'the application'* stating *'Actually, I want to be connecting with people (..) at those critical times'*.

Helen was undertaking the course on a part-time basis, a mode of engagement that meant she focussed on clinical practice skills and nursing theory. Biological science modules are taken during the second part-time year enabling students to engage with practice from the outset. For Helen, the part-time route enabled her to continue as a self-employed allied healthcare practitioner.

Pre-course personal statement

In a brief but well-crafted personal statement, Helen effectively conveyed the message that 'the time is right' for her to start a nursing programme, suggesting that personal, occupational and educational pathways had converged. Not only was this the result of development and maturation but a conscious decision requiring personal sacrifices in order to take advantage of the opportunity.

Throughout her statement, Helen sought to reassure the reader that she had a realistic view of contemporary nursing. Without extensive first-hand experience, she drew on her observations and evaluation of 'caring' situations involving family members, outlining the capacities and characteristics that she believed are required of a 'good nurse' (knowledgeable, skilful, patient and an effective communicator). In doing so, she established a very early connection between personal experiences and anticipated professional roles. Drawing on her allied healthcare practitioner role Helen made a case that she possessed the values that underpin this professional role.

Helen's confidence and positive self-regard was conveyed in her willingness to acknowledge past anxieties and uncertainties about how she might react in some clinical situations. This very short, single sentence paragraph provided the opportunity for Helen to story overcoming her own barriers and realising the '*privilege*' of caring. This powerful word would probably have stood out for the admissions tutor and resonated with the nursing image of social justice and altruism (Ghadirian et al., 2014).

In her final two sentences, Helen made explicit identity claims about her nature as '*a caring person*' and belief that she had the capacity to '*be a good nurse*'. She returns to her message of maturity and realism by suggesting she had '*an unromantic view of the role*' and a desire for '*the training to make it my career*'. In doing so, Helen storied and promoted those characteristics that she believed made her different to 'typical' or 'traditional' nursing students by emphasising the apposite nature of her application.

Meeting in Month 1 (Pre-clinical)

From the very start of our meetings, Helen needed little encouragement to share her stories, taking advantage of the opportunity to intersperse these with opinions and evaluative comments that provided a contextual landscape. In 1H1 Helen responded to the open invitation to '*tell me your story*' by providing a recount of the experiences she identified as significant to how she came to be on the programme. The story flowed easily and seemed to have been told before. To whom was not discernible, but it seemed the links between experiences and meanings were being confidently performed.

She talked initially about a childhood desire to be a nurse and the attributed influences that diverted her from this course. It was clearly important that she established a temporal dimension to her story with the long-held desire acting as the justification for her current position as someone now addressing an unfulfilled dream.

'Erm, I wanted to be a nurse as a child (.) and then (.) I don't know if it was just something to do with the eighties...it was almost from my school that if you were academic then that wasn't the route to go down and was pretty much discouraged,

by peers and, (.) I think to some extent my parents...I think I developed a lot of negative associations with it as well.' (1H1)

Helen returned to explore the internal influences in 1H2, but also acknowledged the powerful desire to *'get away from home'* disclosing that *'I did a degree just because I could do a degree'* and that it was done *'without any idea at all about where I was going.'* A period of homelessness and a lack of direction was used as a counterpoint to illustrate the maturation Helen experienced in the middle part of her life story. She talked about persevering with a non-health related job even though she *'pretty much hated [it] very quickly'* before introducing more recent employment and family roles to emphasise the 'nurse' characteristics outlined in her personal statement. Towards the end, it contains a great deal of reported internal dialogue illustrating Helen's continuing need to rehearse her position.

'And a part of me does think, God I wish I'd done this years ago. God, I wish I had done this straight from school. God, I wish I'd done this in my twenties. So I'm having a lot of thoughts like that at the moment. But then I think, Well could you, as a single parent, aged twenty-eight have coped with the shifts? I probably couldn't. That's not the kind of mother that I wanted to be, you know?' (1H1)

This (1H1) was Helen's abridged *bildungsroman*, a story of formative experiences that contain personal, academic and professional elements intended to provide evidence of growth. Given the opportunity, she continued to expand on many of the elements introduced here, justifying her decision and rehearsing her identity as a beginning nursing student (1H2-5).

In the anecdote, 1H2 Helen recalled the incident she attributed to diverting her from a childhood desire to become a nurse. Stereotypical social images prevalent in the UK in the 1970s and 1980s, reinforced by her family and school, resulted in Helen viewing those who chose to nurse as limited in options because they lacked the intellectual capacity for alternatives. Perceptions at the time, and to a certain extent even now regard nursing as *'not brain work but heart work'* (Buresh & Gordon, 2013, p58) and meant that, for Helen,

choices at eighteen-years-old were based on external pressures to be 'academic' rather than 'practical'.

'...my pals that were not, you know, going to get really good 'A' levels, were going to do nursing...And then I got to [a Scottish] University and discovered there was people doing degree nursing. I thought, Why the hell didn't I do, you know. But it was too late. I'd made all my (.) I was in a different place really...And there are probably an awful lot of prejudices that I'd managed to put together on my own...But when I left school, if you did badly in your 'A' levels you did primary school teaching and you did nursing. (1H2)

Helen positioned herself as honest in her admissions and her previous perspectives admitting *'I would have absolutely been influenced by what I perceive was the norms.'* The story provided Helen with the opportunity to present herself as someone personally transformed by age and experience with greater self-confidence and a more sophisticated viewpoint. Her apparent annoyance, embarrassment and discomfort seemed a critical part of the telling, framing the story and binding together Helen's past and present beliefs about nursing and herself as a nurse. Of all the participants, the ubiquity of emotions and their function as the glue of identity was most clearly evident in Helen's stories (Haviland-Jones et al., 1994).

In 1H3, Helen added further context to her *bildungsroman* whilst also ameliorating the discomfort of her 'confession'. Her explicit identity claim was that she is *not* one of those people who she described from school but that she was impressionable and lacked focus. In a very short recount with a fractured chronology, Helen sought to legitimise her previous study by repeatedly emphasising the status of her previous university. She presented her past self as a reluctant student whose early career decisions were based on materialistic and short-term desires. By presenting her past self in these terms, Helen seemed intent on highlighting the contrast with her contemporary self-image as caring, thoughtful and committed, using 1H4 to illustrate her authenticity.

Helen recalled two incidents from her time working in local government, one where she risked challenging her manager on a matter of principle and a second where she robustly

advocated on behalf of her staff and disenfranchised clients. In this exemplum, she made an identity claim to being a sincere and principled person with the courage to take risks with her own position and security.

'Err, I think I'm quite a serious person. I probably take things too seriously. But I'm really committed to principles, and people have said that about me. I've got a really, really deep sense of fairness...I did really care about the tenants. It really bothered me if they had somebody, you know, antisocial, that was living next door to them and (.) they were struggling to pay their rent...I really, really cared about my staff...But I'd had so many battles [laugh] around the organisation for so many years, it was a bit of a surprise. But I think people genuinely knew (.) where I was coming from, you know, that I was quite genuine about it.' (1H4)

In the process of storying this exemplum, Helen presented her values, establishing a link between her most recent employment and what she regarded as relevant to her future role as a nurse. She claimed to be a virtuous person, a situation that had evolved as a consequence of multifarious life experiences, overcoming personal, professional and academic challenges.

In the bridging section that followed, Helen did not tell structurally identifiable stories but offered observations and opinions to establish context. Describing the NHS as *'this dinosaur that's creaking...a really, really beautiful dinosaur'* and reporting the discouraging reactions of friends to her decision (*'What the hell are you doing?'*) provided Helen with the opportunity to reinforce the claim that she was realistic rather than romantic, a perspective that had prompted its own dilemmas.

'I want to be compassiona-, I suppose what worries me most about going into nursing is, am I going to be given the luxury of knowing you'll be able to do this job well? Because we didn't with our carers...And I think the only thing that I'm not going to cope with is having to leave a ward every day, or the community every day, knowing that I haven't done the job that I could do (.) because of the circumstances.' (1H4)

Murphy et al. (2009) would suggest this is a very real and insightful anxiety given that evidence suggests the caring behaviours of nursing students can diminish as they seek to address an incompatibility between professional and managerial values, consolidating lay and professional beliefs about the nature of caring. Here Helen's comments linked her past experiences, her imagined future self and her anticipated emotions.

'But I'm never going to, erm, just do (.) full-time health service nursing (.) because it's, you know (.) I wouldn't manage it. I'd find it too soul destroying. I'd find it too hard. I'd find it too stressful' (Bridge 1H4 and 1H5).

Rather than a performance of idealism, this was a performance of trepidation and uncertainty that was much more prominent for Helen than the other participants at this point in their journey.

Helen's final narratively structured story from our first meeting added richness and detail to the skeleton outlined in 1H1. This was the transformative story containing the crisis that prompted her re-evaluation to make meaning of events. Helen initially presented herself as the obstacle, admitting *'I did not apply myself at university at all'* (1H5). She wove together snippets of her life including being married, having a daughter and being homeless. She did not dwell on how homelessness impacted her personal identity but the implicit claim was that she had first-hand experience of significant adversity and this prompted a realisation that *'this mucking about and (.) drifting was not (.) a possibility anymore'*. The potential impact on the personal identity of homelessness and the resulting stigmatisation was hinted at and yet Helen choose to limit the detail she disclosed in this context (Schneider & Remillard, 2013). Each brief mention served to suggest that her identity drew on experiences of suffering and hardship creating the canonical storyline of overcoming adversity (Booker, 2004).

Erm, so I did work really hard with that [diploma] and, you know, even though I was working full-time before I finished and single-parent, I absolutely made sure that I passed it and whatever. I've taken my job then really, really seriously, really seriously, for the last seventeen years.' (1H5)

The significance of Helen's repeated justification stories was underpinned in her closing comments where she confided that *'this time last year (.) I was not going to be doing this'*

(1H5). She then listed a series of events that included her father's illness, her daughter's departure for university, dissatisfaction and resignation from her long-standing job and beginning an independent health-care associated business. Her uncertainty and apprehension about her future seemed to prompt a great deal of self-questioning performed during the course of our meetings. Having established a developing degree of affective commitment during the previous stories, Helen revealed her 'safety-net' should she feel unsatisfied with the experiences and professional identity improvised as other aspects of her persona evolve.

'And I've, you know, I've got, Well if it all goes to hell, and I keep, I used to say to people at work, If it all goes to hell, if it all goes to hell, I'll just go back and be a work for an agency...But part of me is like, Is this really going to be OK? Am I really going to pull this off?...Am I really going to be happy?' (1H5)

At this stage, Helen, like Beth, had very limited context-specific material upon which to base her clinical identity performance and so focused on the academic and personal. Her student identity was characterised by an intriguing mix of a 'second chance education' opportunity and a strong sense of academic capability. Her personal identity demonstrated certain congruence with Andrea, namely that she is also at a threshold.

Meeting in Month 5 (Returning to university)

At the outset of our second meeting, Helen focused on her recent clinical placement experiences and suggested she was *'coming into nursing from quite a different place from a lot of other people'*. She emphasised her contentment with the focus on fundamental care practices and interpersonal skills given her very limited prior experience in this area. As well as addressing her own objectives, she was cognisant of the social expectations and how she might fit in by demonstrating her willingness to engage in fundamental care work.

'And I absolutely threw myself into that side of the job, which made me, you know, I think that went quite a long way with colleagues...I actually, you know, I suppose for the first three or four weeks I just really, really enjoyed the HCA role, erm.' (2H6)

This was reinforced to both of us in the telling of 2H6 where Helen recalled a care episode involving a ninety-six-year-old woman with dementia. Helen expressed her surprise at

having enjoyed this experience, openly acknowledging *'I wasn't really looking forward to the dementia side of things because I don't like mental health...I always thought it was an area I wasn't, erm, an area that wouldn't, I wouldn't be suited to'* (2H6). In the portrayal, Helen engaged in meaning making, forced to challenge some of her assumptions about dementia and her own capabilities. Care was understood to be simple, described as *'they just want lots and lots of reassurance and comfort'* which she felt confident to provide. Without exploring this in more detail, the story quickly moved to consider the practical demands on the staff Helen was working with and her appreciation of the limits to her responsibility.

'And if I have to do that relentlessly six days a week in the frustrations of an overstretched health service etcetera, etcetera, I will be at risk of not being as sympathetic to people you know.' (2H6)

On reflection, Helen was providing an introduction to a more emotional story, establishing some distinction from and attempted rationalisation for the observed practices of others about which she is not comfortable. She uses the phrases *'positive'* and *'negative'* to distinguish her experiences, the latter referring more accurately to experiences of adversity and these included caring for someone after they had died.

Rather than a tale of the emotional reactions to a patient's death which new nursing students often find troublesome and painful both from a personal and professional perspective (Ek et al., 2014; Parry, 2011), this was a transition narrative (Ibarra, 2007) yet another story about *'fitting in'*. Helen was dismayed when she witnessed the HCA she was working with talking to the patient as if they were still alive and loud enough for other patients to hear. In the telling, Helen became very animated, mimicking the HCA and labelling her own emotions as *'frustrating'*, *'annoyed'*, *'upset'*, and *'anger'*. Some of these were clearly directed at the HCA, who was characterised as *'a bit stupid'*, *'insensitive'* and *'unimaginative'*, but the most extreme emotions, Helen suggested, were because of her own reaction. The practice was not challenged by the ward manager creating dissonance between Helen's personal perspective, the prevailing culture and what she articulated as her own lack of courage in not challenging the practice.

'And I wanted to kill her, I really wanted to kill her...I just thought it was really undignified and horrible. And the really surprising thing was that care assistant thought they were being really dignified...And the Sister was with us and the Sister didn't, I mean if it was me, I mean I was absolutely tempted to say, Shut up!' (2H7)

The intensity of the emotion later relabelled as 'rage' and fury, provided Helen with a mechanism for portraying the significance of her discomfort. This was the result of the need to 'fit in' contrasted with the personal sense of self.

'But it's, then that's the difficult thing about being a student nurse, isn't it?... And that is a difficult balancing act...I want to get to be part of the team and get along with people, at the moment, more than I want most other things...' (2H7)

In the telling, Helen rehearsed her reaction to a new and informed audience (me), performing her professional identity through the clear expression of values and possible alternative actions in order to achieve some degree of harmony.

'I didn't feel, I think if it had been me and her or me and her and another HCA, but the fact that the Sister was there. [laughs] And there was a Return to Practice [formerly qualified nurse], there was bloody loads of us there actually...so I just felt, you know, this isn't for you to say to that HCA, Do you think we should keep our voices down? But I should have done.' (2H7)

A contrast between personal beliefs founded on memories of her mother's death and the prevailing accepted practice culture, a perceived lack of agency and an awareness of her position within the clinical hierarchy combined to make this a story with significant transformational potential. The story was one of uncomfortable compromise but the telling provided an opportunity for Helen to perform a version of her hoped-for future self as a student nurse.

Helen's frustration triggered the next brief anecdote concerning her changing awareness of the nature of the clinical environment from lay to professional (insider), described as '*a bit of an eye-opener*'. Again based on the experiences of family members in hospital, Helen questioned the objectives and organisation of practice.

'Because when you've got your parent and when you've got a relative or you're in hospital yourself, you just think, Right so they're obviously treating me and they're waiting for something to happen, such that they'll discharge me. But that's absolutely not the way it is, is it? (2H8)

She was aware this might be an incomplete picture but clearly provided her context for understanding the world of clinical practice.

'And it might have been that I didn't, it didn't feel like that. It felt like seventy, eighty percent of people were just stuck there. And actually, medically, we weren't doing anything, other than just caring for them'. (2H8)

This suggested Helen conceived the hospital as a place of targeted action to achieve progress and, ultimately, discharge. Her insider perspective of the clinical environment was presented as strange and unexpected, contrasting significantly with that of a service user. Helen was challenged by the apparent lack of progress as her imagined clinical world and her role within this failed to match up. Later, in 2H11, she acknowledged there were plans of care but illustrated her lack of clarity over the objectives as a nurse.

'I see the care plan to get you [the patient] to your home again, but I don't see any medical plan. So it is almost just like a maintenance... And that sort of brought me up a bit as well because I really do enjoy the HCA job, I could happily do the HCA job, happily. Erm, but then you think, Yes you're right actually! Yes, we should be medically improving things, shouldn't we?' (2H11)

In 2H8a Helen recounted an archetypal experience, recognisable to, if not shared by all nurses, the significance of which would also be evident to non-nurses. Like Andrea's story of her first death experience (A11) and Denise's tale of mundane jobs (3D24), this was portrayed as 'rite of passage', a necessary experience that qualified and legitimised Helen's identity as a Student Nurse.

'So the nurse was changing his suprapubic catheter and he was talking me through it because he knew it so well...And I was , Oh really hot. I thought, I'm going to go. I'm going to go. So I had to leave. Just absolutely went white as a sheet apparently, sort of really hot, ringing in my ears.' (2H8a)

It was a gateway story in which Helen performed the expected response of the non-nurse to witnessed events before moving to show her appreciation of, and the need to control her

reaction in order to become a nurse. She expressed her embarrassment and shame but also her sense of responsibility to overcome this. She was keen to end the story by emphasising her progress.

'Because I don't have any problem with toileting or blood or sick or anything like that, at all. And I watched another stoma, err bag being replaced and that didn't bother me.' (2H8a)

Here Helen was claiming her status as a becoming nurse. Occupational expectations and assumptions were embedded within the story and its telling provided Helen with the opportunity to represent her progress towards achieving these.

Similar examples of Helen's transitioning identity were addressed in 2H11 where she recounted meeting her former primary school teacher whilst working in the clinical setting. Helen's uncertainty in managing this situation was informed by her own father's experiences as a teacher and his desire not to engage with former pupils. This personal context and the nature of traditional pupil-teacher relationship provided the back-story in this instance. Helen was unsure about how to act. She was engaged in constructing her understanding of the nurse-patient relationship and this situation added an extra layer of complexity. As a result she sought guidance from her mentor on initiating and managing this encounter.

'She was my primary school teacher. She was my infant school -. Yes, junior school teacher, yes. So I didn't know how to handle that. But eventually, I spoke to the others and said, "Do you think she'd, you know, mind if I said Hello?"...My dad would definitely prefer that his nurse was not an ex-student, you know, so I didn't want to just storm in.' (2H11)

Rather than address the tensions in shifting relationships, Helen focussed on the patient's perspective of her care, restating ideas introduced in 2H8.

'And she said, "Well, they're really good at getting you the right outfit aren't they? And you know! Have you got enough to drink and tidying up. But they haven't got a bloody clue what they're doing". And she meant, to get me out of here.' (2H11)

In this story, Helen seemed to be employing the words of the patient to communicate her own thoughts and doubts. At this point, her affiliation with health care staff seemed remote

in spite of her stated desire to fit in. Helen was clearly articulating her nominal group associations in a story that suggested the salience of her lay identity was greater than that of her professional identity. The storytelling environment, separated by time and location from where these events had occurred provided an opportunity to voice her uncertain yet generally critical standpoint in safety.

The claim of her capacity to empathise formed the basis of a care incident story that also encompassed personal learning with a professional impact (2H9). Helen detailed an establishing relationship with a person who had recently undergone surgery and was awaiting discharge. Discussing his ambitions and desire for greater independence, Helen admitted she was forced to question her own assumptions and prejudices concerning people who are obese. Helen openly expressed her initial negativity towards people who were over-weight, attributing their circumstances to their own actions.

'But then with him it was like, well yes, there's just something, it's really, really beyond your ability to stop this, isn't it, you know...I felt it softened my view of, erm obese people in quite a big way I think really.' (2H9)

Helen framed the relationship by claiming *'I really got fond of him'* because of the closeness in their ages and her perception that he was *'an emotionally vulnerable person'*. The story was one of communion and exploratory narrative processing as Helen sought to embed her changed view of herself, personally and professionally, in the details of this clinical encounter. Performing her disapproving attitudes without reservation or embarrassment (*'You think, For God's sake, just move a bit quicker, you'll lose weight'*) served to reinforce the significance of this change in the context of her developing nurse identity. It also served as an expression and performance of her 'solidarity' with the patient; the ability *'to imagine and identify with the suffering of others to the extent that [one is] motivated to respond to that suffering'* (Rolfe, 2014, p1459).

Towards the end of our meeting, Helen recalled an incident working with a senior member of staff claiming she *'had me learning within two minutes of meeting her'* (2H12). Without

providing a detailed explanation of what they did, Helen recalled the dictate to *'stick to me like glue'* so she was able to witness exactly what the experienced staff nurse did.

'You think, Oh yes, shit, this is really stressful isn't it? You know, just the sorts of things that she's juggling in her own head all of the time. And all the responsibility is on her until all those things get done.' (2H12)

Asked by me to *'paint a picture'* of the experience, Helen began to contextualise once again the events storied in 2H7 and her reluctance to challenge the practice of others. Helen justified this here with an identity claim that *'we're all just nicey, nicey, nicey, we're not really managers, not really authoritative'* and yet she went on to suggest this was exactly what exemplified the nurse she learnt most from (3H15).

'But you do, with the best will in the world, you do need people who are going to think for themselves, don't you? Which a lot of them do, it's just somehow the responsibility of things ought to be shared out a bit more shouldn't it?' (2H12)

Helen storied this mentor as a potential role model, someone who *'had a really nice manner about her, but she was authoritative'*. This was the first story where Helen's own previous expertise as a manager had been acknowledged as she came to see that caring and managerial skills could co-exist in the same person.

A thread that ran through many of the stories told at our second meeting (2H8, 2H9, 2H10 and 2H11) concerned the tension between *'doing the HCA job'*, her growing awareness of how this was distinct from the role of the nurse and her desire to make a concrete impact on people's experiences. These were stories of contradiction and uncertainty underpinned by performances of and statements about Helen's developing application of personal values in clinical settings.

Meeting in Month 8 (Nearing year's end)

Helen's opening story told at our final meeting (3H13) combined a number of instances used to rehearse how she planned to manage in a competitive clinical learning environment. Fellow students were characterised as *'very pushy'*, tending to demand attention. Helen portrayed herself as unwilling to be drawn into competing for attention. During the anecdote she expressed frustration and annoyance at her student colleagues.

'Who put you in charge? I'd be like, Will you just shut up!'

She also expressed her discomfort with the apparent frenzy over mentor's time and ambivalence at not having a *'burning ambition'*, all tempered by an acknowledgement of the concern that she might be *'too passive really'*. Her candid self-disclosure of being *'pretty lazy-minded'* and that she will *'only work to a deadline'* served as an opportunities to represent herself as self-assured and willing to be viewed by other students as an outsider. She went on to question her own motivation by suggesting that she may not finish the programme. She emphasised her alternative image by contrasting her own behaviour with the reported actions of another of the research participants.

'So I don't feel this year's been a waste of time by any stretch of the imagination at all, you know, I really, really don't. But I suppose, part of my lack of motivation is, is like, Well six years! Come on, face it, you're not going to be doing this for six years, you're not....but I don't have, for instance, Beth's hunger just to know it. Beth just wants to know it, not necessarily for an outcome, which, you know is really admirable, and I wish I was like that but I'm not.' (3H13)

Helen was performing her uniqueness alongside an ambiguous affective commitment towards both her studies and her clinical role. She was portraying herself as a pragmatist with limited emotional attachment to the profession, a situation that research would suggest has the potential to negatively impact on retention and performance (Clements et al., 2016). Asked directly if she viewed herself in the future as a nurse, she replied *'No, I don't really'*.

Exploring the story behind this assertion, Helen retold her life story (1H1) and occupational history (1H4) the outcome being that she viewed the end point of the programme (to be a nurse) as secondary to the process (experiencing becoming a nurse). This was a significant revelation for me. As a co-constructor of the story, adjusting my own assumption that all students want to be nurses was critical to effectively analysing this story.

In relation to her previous job, Helen told of how managerial responsibility affected her. She disclosed existing in a *'constant state of anxiety'* and suggested *'I just take it all too seriously'*. She made the claim that in order to *'avoid having to face up for being lazy-*

*mind*ed, is just to do loads of hours' (3H14). This resulted in discontentment and an acknowledgement that she was imagining an alternative to this previous role.

'So seeing myself as a nurse, I don't know, I don't know. I just really wanted to do it. I just thought, Oh my god, imagine being able to do that, you know...Imagine doing that every day, that would be nice. (3H14)

Helen was engaged in storying a future world informed by who she wanted to be as much as by the observations and insights she had accumulated over the preceding few months. She went on to illustrate this through a tale concerning her role as a foot health practitioner where events had caused her to feel very anxious about her own practice. Helen caused someone's foot to ooze having pared the skin too far and was concerned this would then ulcerate. She used the situation to justify her desire for greater confidence based on knowledge and skills.

'I really want to meet those situations and not think, I don't know what the hell I'm doing.'

Helen's future self is calm, knowledgeable and self-assured. Her aspirations related to her general abilities rather than herself as a nurse and yet she was keen to stress her commitment to the profession.

She reinforced this commitment when she suggested that *'if I won the lottery, I would pack in the feet and I would do the nursing full time and see where that took me'* but the situation in which she found herself demanded she remain circumspect. This might be considered an example of what Ibarra (2007) considers *'tentative selves'*, produced during the transition before committing to identity claims.

'It's not like I've got this picture at the end, you know, end of the rainbow. There's the finish line and that's what it looks like, isn't it. It's very much more, Look, this is better, definitely better than what I used to do. I'm more comfortable doing this than I've ever been doing, you know, anything else.' (3H14)

When she was not sure of the details of her imagined self, Helen reverted to claims about her own values (*'It gives me opportunities to just give moments of kindness to people'*) and statements about what she does *not* want to be.

'I don't want to be, you know, a nur- practitioner. I don't want, I not looking for a massive salary. I just want to be able to deal with simple situations.'

Interestingly, when compared to some other participants (Julia) Helen did not commit to imagining herself as a nurse in the future, preferring to focus on the abilities and experiences of becoming. The tentative self is not expected to adopt all the rule and obligations, enabling Helen to safely perform a very different persona to fellow students whilst also engaging in practices to achieve belongingness (Levett-Jones and Lathlean 2008)(2H6, 3H13).

Helen did however express an admiration and degree of envy concerning the abilities of other students. This was captured in her anecdote about general classroom interactions and included direct reference to two of the other research participants³.

'I'll have a conversation with Beth and think, Oh flipping heck, I really should do some reading [laugh], you know. And seeing Patience [pseudonym] and other people, they're you know, they love it, they absolutely love it, and Denise and Chloe [pseudonyms]...And that's really, you think, Oh I want to be like that. That would be great.' (3H16)

Helen portrayed herself as someone who was still waiting to 'take off', and feel engaged to the same extent as some of her fellow students. That she was not was a feature of her rather contradictory identity claim. She suggested she was '*not hugely anxious about it*' and had '*never academically studied*' but had the capacity to '*apply myself really hard*' when the subject '*really does float my boat*'. Once again Helen performed a degree of ambivalence towards the act of studying and the topic itself, possibly as a safety line in the event that she would ultimately be unsuccessful.

'But I certainly wasn't really, really stimulated by my English degree. And, err, so far, I haven't been really engrossed in my nursing either.' (3H16)

This represented a contradiction between the stated and performed desire and the reality of Helen's experience. The degree of commitment was evident in the stories told by other

³ These were Beth and Chloe. Chloe was involved until Month 5 but was unable to attend the final meeting and so her data was not included.

participants and yet Helen frequently storied herself as only peripherally engaged. Other roles and interests were offered at this point, that enabled Helen to portray herself to herself and to me as a rounded person in spite of this uncertainty.

'I mean I'm not a stupid person and I'm not completely lazy because I am interested in current affairs and all those sorts of things, and music and art and theatre and those sorts of things. So it's not like I'm indifferent to stuff, everything that's out there, I'm not.' (3H16)

The impression was that Helen was portraying herself as expectant, waiting for experiences that would enable her to story herself in a similar way to her colleagues. Interestingly, Helen then proceeded to tell a tale of events that might generally be regarded as prototypical for student nurses (3H15).

Recalling an anecdote from practice Helen told of an interaction that seemed to characterise her personality and crystallise her desire. She suggested *'the best shift I had was with my mentor, who's deadly straight, erm, and challenges you'*. She went on to explain how the mentor had expressed surprised at Helen's limited knowledge of the uses and actions of medicines. The telling of this story illustrated Helen's understanding of the mentor-student relationship in the practice context. She characterised the mentor as a teacher (*'she sees herself absolutely, her job is to be a teacher, without any vanity, she just sees that as her job...'* 3H15) who took every opportunity to facilitate learning, clarifying expectations and issuing challenges.

'And not that she's shitty but she's, you know, Look, you should know this, you know? That works really!' (3H15)

Helen was impressed by this approach. She was unfazed by the clear and challenging expectations which clarified her role as a learner. She emphasised this through her own agency, telling how she successfully managed the situation.

'I took the BNF [drug formulary] on holiday to France, you know. It motivated me to say, No you'll really enjoy taking the BNF to France with you and learning about different drugs. You'll really enjoy, and I did!' (3H15)

In this instance Helen was performing her capacity to actively engage when the conditions suit her. Crucially this involved the demonstration of a reciprocal identity (teacher-student) that matched Helen's preconceived image.

Helen portrayed her self-image as someone with a mature and realistic understanding of the roles and relationships between mentors and students.

'...I don't want to be a pain in the arse to anyone that works there full-time. Whereas the others are very, you know, Look what I've, you know, I'm not here to be a health care assistant...I want to be useful...It doesn't bother me to the same extent.' (3H15)

She portrayed a more considered and less demanding persona, appreciative of the demands she made on mentors' time and energy when she was benefitting from the learning opportunities created. Central to this seemed to be Helen's sense of the reciprocity between student nurses and those working as health care professionals. It also illustrated how significant this relationship can be in the process of developing identities.

Helen ended our final meeting with a brief recount and a timeline of experiences that seemed designed to underpin an important personal message, namely that *'It would be brilliant to be motivated and absorbed without being driven by sheer fear of failure'* (3H18). She recalled anxieties of the past, restated her present uncertainty and her anticipated hope for the future. Helen made identity claims at various points during our meetings, many informed by the notion that *'it's not really logical'* for her to be on the programme.

'It's almost like something instinctive. It's keeping me, it's just instinct...And it is illogical, it is totally illogical, I get that. I do really get that...but I just feel really drawn to it.'

At this point, Helen was explicit that her identity is a series of performed contradictions.

'I don't consistently really enjoy it but I do enjoy it and that's as good as it gets, isn't it?' (3H18)

Helen portrayed herself as a seeker of contentment whilst contrasting this with a tendency toward never being satisfied (3H17). Her journey towards becoming a nurse seemed more important than the image and notion of being a nurse in the future.

While some meetings with participants ended neatly and with a conclusion, my final meeting with Helen served as an opportunity for her to rehearse her uncertainty with a different audience. I assume that while she told these stories she was monitoring and

reacting to my responses. Mindful of this, I was conscious to remain neutral but interested in proving Helen with the forum to express and explore her identity claims.

Coda

In the course of our meetings, Helen made noticeably fewer explicit identity claims compared to other participants but embedded these in the performance and portrayal of her stories. She cast herself as different to others, a feature that was performed in both the university and clinical practice contexts. Helen performed a pre-course identity based on stated values that she considered commensurate with professional values. Her commitment is portrayed in these terms also given her limited practical experience. Throughout, Helen claimed a pragmatic insight in relation to both key environments. Her peripheral positioning represented the tension between her degree of commitment and her uncertainty about her future self. During our first meeting, she actively storied herself in order to legitimise and justify her place on the programme. By the second meeting, she was storying herself in a nursing role through recounts and anecdotes that emphasised changing relationships, and degrees of agency in her newly acquired role. In the final meeting, Helen was engaged in the active process of holding both her identity in the university and clinical contexts 'at arm's length' as she performed a transitional identity, withholding commitment as a means of managing risk to herself.

Postscript

A year after completing the data gathering, I returned full transcripts to each of the participants, not for checking but so they had, what I hoped would be, a valuable chronicle of their early experiences. Only Helen responded, expressing her contemporary evaluations of this historical artefact. She expressed concern that *'I come across as insensitive and inarticulate'* and that she *'express(es) some criticism of nursing colleagues and the content of the degree which I wouldn't do with everyone normally'*. At the time, Helen's stories were emphatic, laden with emotion and surprisingly candid. Reviewing the stories after a further years' experience, Helen seems embarrassed by her naivety, understood here as innocence or a lack of sophistication rather than ignorance. Her response serves as a crucial reminder

of the importance of the three commonplaces of narrative inquiry, temporality, sociality and place (Clandinin et al., 2007). The events Helen storied were located temporally and formed part of her past, the then present and future. Her perspective had changed significantly as would any retelling of the events one year on (Wall et al., 2007). These stories concerned the person and social conditions prevailing within a specific location including the relationship between Helen and myself as participant and researcher. I am extremely sensitive to the comment that this *'might be a future lesson for me'* and that she does not *'relish the idea of exposing the fact [of her becoming persona] widely'*. My ethical responsibility to Helen has inevitably influenced the way in which she has been represented in this chapter.

Chapter 8 - Julia

Introducing Julia

Julia was the youngest of the participants having recently completed an Access course at the local college after finished her compulsory education. From the beginning she appeared to relish the opportunity to share her experiences and perspectives on the programme, nursing and her future career progression. I was unexpectedly surprised that she was the most definite of all the participants about how she saw her future, what she intended to achieve and how she planned to make this a reality. With her ideas already established, it meant our meetings were faster-paced than the others. Julia 'shot from the hip' when she talked without appearing to consciously construct the total of 22 stories she told. Possible explanations for this became apparent during the course of our three meetings between Oct 2014 and May 2015, Julia had been identified as having dyslexia while at college. This impacted on the way she processed information and sequenced stories. She often expressed 'potted' or abridged versions to begin with, requiring more frequent prompts and requests to expand the details which developed in noticeably more narratives (6) and exemplum (6) than other participants.

Amongst the participants, Julia was the only one who could be described as a 'traditional' nursing student (Jeffreys, 2012). She was 20-years old and lived with her parents in a village an hour's drive from the campus. On leaving school, she had chosen to undertake a two-year extended diploma in Health and Social care rather than enrol on 'A' level courses. This enabled her to complete placements working with children, older adults and people with learning disabilities with the motivation that *'I'm gonna get more experience before I go into university'*. Like the increasing majority of students (65% according to the Royal College of Nursing, 2008) Julia was engaged in paid employment immediately before starting the programme, completing two years as a full-time support worker in a home for adults with learning disabilities. She spoke with real affection about the people she cared for and her frustration at the restricted progression of her career due to the declining numbers of training places for Registered Learning Disability Nurses (Glover and Emerson, 2012).

Suggesting that *'If you get [a] general [nursing qualification], you can always specialise'* and *'they're saying that adult nurses should be able to cope with any different person'* she applied for and secured a place at her first choice location to study adult nursing.

Pre-course personal statement

Julia began her personal statement with several self-assured and bold claims about herself that she believed were likely to capture the attention of the Admissions Tutor.

'I have always wanted to care and support people. I am confident I have the values, beliefs and compassion to become a competent professional nurse.'

To support this she told of her general care experiences and endeavoured to contextualise and demonstrate the alignment of her personal and professional values.

'I have also had the opportunity to be a key worker, ensuring that my key person has all the necessary things to make their life as full and rewarding as possible.'

A major focus of the text was on the practice skills or tasks Julia believed are central to nursing. She provided a short list of the actions she had undertaken and referring to 'tasks' carried out by registered nurses. Her image of nursing seemed to have been constructed in terms of these activities and she conveyed a sense that nursing is, almost exclusively, practical. She went on to talk about managing and organising care, uniquely among the participants, hinting at her a desire to build a long-term career.

Julia was explicit about how she values learning and used examples across the statement to illustrate this. She worked to present an image of herself as someone who could apply classroom knowledge to practice situations.

In the final section, she sought to illustrate how her social activities had a nursing relevance. These provided opportunities to state personal characteristics which she considered important for both the practice (hard-working, caring, effective in a team and individually) and academic settings (organised, good time management). She sought to describe her personality, make explicit professional identity claims and emphasise her capacity in the longer term.

'I always offer help and support which is the most fundamental aspect of becoming a nurse' ... 'I strongly feel that I can succeed in a career in nursing...'

Meeting in Month 1 (Pre-clinical)

Julia was one of the later participants to respond to the research invitation but she seemed enthusiastic from the beginning. Given the initial request to share her stories, Julia painted a sketch of her work and study experiences, flowing from point-to-point with a mixture of descriptions and evaluations. She presented herself as someone who knew her own mind and had an inner confidence about the validity of her world view. Asking her to focus resulted in many stories with narrative structure as well as exemplars where Julia could portray herself and the experiences that gave rise to her values and beliefs.

Julia began her first exemplum (1J1) with a personal disclosure that typified her open and transparent approach to our meetings.

'I was bullied at school badly by a group of older lads, um to the point where it was physical and I went through a really, really hard time, and to the point where I was self-harming and had counselling sessions and everything.'

Julia dismissed the counsellors and her school suggesting *'they didn't want to know'* and *'They don't care'*. She then claimed *'it was a case of deal with it yourself [laugh]. So I did. I did deal with it myself'* (1J1). Acknowledging that she still experienced the repercussions of these events, Julia represented her empathy with *'vulnerable people'* by asking *How can people be this nasty?* She made clear that it was her personal experiences and sense of social justice that motivate her to care for others. She continued to claim that caring is *'Everything. I focus my whole life on it'* and suggested that her university work would become *'my [her] life'*.

These disclosures provided Julia with an opportunity to retell this significant story from her past (1J1). The emotions associated with fragility and victimhood that might be expected were instead replaced with those of robustness and pragmatism (*'I just (.) grew up with it...Grew up. Got stronger. Got more wise'*). Rather than represent herself as a 'victim' Julia sought to author herself as a 'casualty turned rescuer' and present her decision to start the programme in this context. I also felt it provided a strategic method for Julia to evaluate *my*

response to her disclosure. Based upon this, she will have decided what and how to share future stories.

Developing her persona from 1J1, Julia sought to underpin her identity as a champion in a story that she alluded to in each of our meetings. While a college student (further education) on placement, Julia witnessed poor practice from carers in a residential home, recalling instances of people being woken and helped to wash and dress to accommodate the home's routine rather than their wishes. She told of staff that would 'sneak' fresh fruit and vegetables into the institution because the owners refused to provide this. Julia investigated and discovered a reluctance by staff to report incidents or for residents to make complaints (*'Oh don't we don't like to complain but'*). She raised her concerns with college tutors and, after escalating this to the Care Quality Commission (CQC), the situation was investigated and resolved.

'We did go to the CQC in the end. And it is sorted. Yeah, there's a big change.' (1J2)

The narrative structure and familiar plot line of 'Overcoming the Monster' (Booker, 2004) provided Julia with the opportunity to portray herself as the heroine and therefore, powerful. In her evaluation, Julia claimed that *'It's definitely changed me...I will stand up and say something if I see it now.'* Interestingly, Julia suggested she would raise any future instances of witnessed poor practice directly with the person concerned. There was no acknowledgement of fear or hesitation and no sense that she was concerned by the potential personal costs (Jackson et al., 2010). While this may be explained in terms of naivety, the plot of the story, juxtaposed with her identity claim in 1J1 suggested that Julia saw herself as uncompromising, fearless and indomitable.

During the bridging section to the next story, Julia claimed that staff working at the nursing home had discouraged her from becoming a nurse. She reported the dialogue as direct speech in order to indicate her resolve and career objectives.

'Because if someone says "Don't do it", I'm gonna do it. And (.) you know, it's not for them to choose my life. And then I say, Oh, I'm gonna go into management. I'm gonna be a matron one day...I will prove everyone wrong' (Bridge 1J2 to 1J3)

In this declaration, Julia coupled her personal and professional identities and engaged in authoring herself a future. While mentioning her aunt, a former hospital matron, she also

recalled another nurse whom she characterised as *'a real inspiration because she did- she still wanted to care.'* This brief passage revealed the professional characteristics Julia believes make a good nurse. These included dedication to complete what had been started and a willingness to 'roll your sleeves up' ensuring everything is done *'correct, by the book.'* Her declaration concluded with a view of her future self that seemed to be the benchmark by which she evaluated the nurses she came into contact with.

'And I think actually, Yeah, there's being a nurse but then there's being a good carer nurse. So (...) that's what I want to be.'

She began 1J3 by making an explicit claim that *'I think I'd be a good nurse'* and then offered an exemplum to support her case. Julia recalled how, having previously cared for many people with cognitive and communication impairments, and she understood that they often required time to express their wishes. Her frustration with colleagues who did not provide this individualised care was offered as the basis for Julia's management aspirations.

'I want to be matron. I want to run a ward. I want staff to work under me. I want good staff to work under me.'

She portrays her aunt (*'when she was in her prime'*) as someone who was *'all about having fun but she was firm. [If] You worked under her, you were good'*. She recalled observing her aunt tackling what was considered sub-standard care in a firm but fair way that Julia characterised as good leadership. Again, she concluded her story with a declaration.

'And I think I'd make a pretty good leader...When I want to get to the top I don't want to be pushed out of it. I want to stand my ground. I want to make a change.' (1J3)

The determination to challenge poor practice told in 1J2 recurred in 1J4 as Julia told the transformative and redemptive story of her dyslexia diagnosis. Julia's disillusion and resentment towards her initial school learning experiences had been replaced with a new perspective as she increasingly learnt more about her own particular abilities.

'I was effectively lost before I got diagnosed. So like, basically I was telling my mum, I said, "I'm retarded!" I said, "Mum I can't do it ...I don't understand why I'm being pulled up for this"...They picked it up. Picked up the dyslexia as and I genuinely thought, Great, that's it. That's my dreams gone...Actually, it's lies. You can do whatever you want...So it's changed my world basically.' (1J4)

Julia's transition was from seeing herself as 'stupid' to someone who embraced her dyslexia as part of who she was and would fight for what she wanted (Evans, 2014). She had struggled when she was expected and required to learn and communicate in particular ways that did not suit her.

'And once I found out my capabilities (.) because they were forcing me to do things I couldn't do...I couldn't figure out why I couldn't do it and it really annoys me when I can't do something....And it was when I got those weaknesses and I explained to people (.) dyslexic, my spelling's not great. Can you tell me now to spell this word, and they spelt it out (.) perfect.' (1J4)

This story, with a narrative structure, was told in three parts, punctuated with other brief stories that added context but have an identifiable form of their own. Julia became very animated telling this story with greater variations in pitch and a noticeable increase in the speed of her speech. She also told it from a first-person perspective in order to portray the nature of the trauma she had experienced and the resolution she had achieved. Her ability to overcome social and cultural obstacles in academic and clinical contexts continued to inform Julia's identity claims in the context of our meeting as well as the image she portrayed of herself in the future. These examples of success reinforced her self-efficacy and had the persuasive characteristics of positioning narratives.

The anecdote addressed in 1J5 might be considered a sub-story of 1J4 but is likely to have been retold numerous times as Julia achieves the relationship with dyslexia outlined above. As such, it seemed to serve as a 'key narrative' or a 'go to' account that was used to neatly package the complexities of dyslexia as part of Julia's identity (Boenisch-Brednich, 2002).

The option to retake a borderline biology examination at college provided Julia with the opportunity to trial a new method of revision. In her telling, dyslexia provided both meaning for past difficulties and permission to explore diverse and alternative methods of learning that would enable her to achieve.

'I struggled at school, quite a lot. I can always remember actually, I took a biology exam, and I only just got into being a 'C', you know on that borderline...So I retook it and I did my revision in a completely different way...And I turned out I got an 'A' so I kind of thought, Actually, maybe I learn in a different way [laugh]...And then, um, it

turned out, when I found out I was dyslexic that I use an overlay now and I write in red...When it's given to me in black, I can read the whole lot and not take anything in. But when I read it in red I can take the whole lot in and give you feedback on everything I've read...Finding that out has helped so much. It is unbelievable.' (1J5)

The story was told as a revelation and had a redemptive quality to it. Julia did not cast her dyslexia as a disability or an impediment but as a feature of her uniqueness as a learner. She performed the anecdote to represent her identity as a learner, empowered to learn in ways that suited her rather than conforming to common but ineffective practices. At this early stage in the programme, before any degree of academic or clinical testing, Julia positioned herself as individual and capable, a thread that was plainly evident in the next story and became something of a recurring identity claim during the course of our meetings.

During one of her nursing home experiences, Julia clashed with her line manager. The incident prompted a re-consideration of her career ambitions. The line manager was cast as an antagonist who attempted to humiliate and remove Julia from a care situation. She cast herself as an advocate, catalyst and an agent for change, roles that Julia considered extremely important based on her own past experiences and which she associated closely with caring and nursing (1J2).

'...when I first started there they [the existing staff] didn't like new people. It was very family orientated around there [clichés]. Anyone new that came in; that's it. You were tried to kick out, and they did, they tried to get rid of me. And I've, being me, I was like, No, I'm not having that. I'm staying put, I'm staying here. And it turned out in the end (.) that not only did I change the way that that nursing home worked, anyone new that comes in, I welcomed them with open arms....And now, everyone new that's new comes in, they welcome them.' (1J6)

Julia portrayed herself as courageous and effective, using this story to present her beliefs about fairness, justice and the way people should be treated. Details about the culture in this nursing home were inevitably omitted, overlooked by accident or design in order to enable Julia to claim agency. Without any positional power, the story was used to demonstrate her potential to have an impact.

'So, that was when I first started standing up for myself, properly and saying, This isn't happening.' (1J6)

This story was used to contextualise Julie's re-consideration and her decision to develop her career. Her unwillingness to accept the culture and position she was being presented with is offered as her motivation to continue her studies.

'I thought, I'm not having this. And that's when I decided I want something bigger. And that's when I started to apply'.

Asked at the end of our first meeting about how she had found the experience of sharing her stories, Julia suggested the activity had provided her with an opportunity to establish conscious links between past events, the present and her anticipated future.

'Er, I never really laid everything out on the table so it's quite nice to see my life from the point to where it's gone and where it's going, if you know what I mean? (R: Umhum) Even when I did counselling they never done this. So it was, it was quite nice to see how I got here (R: OK) from a different perspective and see it from my own perspective. I never really thought about it [laugh]. And now I'm like, Oh, That's how I got here!' (1J6)

Meeting in Month 5 (Returning to university)

Julia began our second meeting in good spirits with a success story suggesting she had begun to establish her sense of agency in the academic setting.

'I've actually figured out how to use the whole library by myself...I didn't actually get a bad mark, but it was just problems like making myself clear and that. (R: Umhum) So I thought, Well I know, I'll just spend a week in the library...So I just stayed from eight in the morning until six. And I just learnt. I'd be using the books. I used everything [laugh].' (2J7)

While Julia briefly acknowledged the assistance of the librarian in the telling of her story, this was clearly a portrayal of her own capacity and autonomy. Her message was that, rather than eschew the library, she had chosen to immerse herself in both the physical and virtual space in order to better understand the workings of this unfamiliar world. At this point in the programme, her relationship with the library was presented in terms of practical skills and effective utility rather than as a source of intellectual stimulation.

'Now I can go up and find anything, so that's made my life easier.'

In this story, Julia told herself that the process of learning and the nature of studentship is not complicated but can be time-consuming. She was suggesting that hard work and dedication will result in success and that she has the capacity to do this. Her straightforward and unequivocal attitude informed not only this story but also the majority of those she told during our second meeting.

Story 2J8 was the first workplace anecdote Julia told about herself as a nursing student. It served to emphasise her authenticity in this new role, a thread she revisited in our final meeting (3J15). It contained details of a novel experience for Julia but one that would be universally recognisable to other nurses and can be understood by a general audience. Julia storied herself into the experience as a neophyte engaged in a rite of passage or initiation into a new world. The portrayal accentuated the drama and the emotion Julia felt which were crucial to the way in which the experience was understood.

'..by the end of the first week I was actually taking out cannulas and everything. They had me doing everything, so that was good...it was kind of nice and quite exciting to do my first nursing based thing.' (2J8)

In this incident, Julia recalled removing a cannula (a small venous access device) from a patient under the close supervision of her mentor. She had watched the procedure being demonstrated by a third-year student and thought she had successfully repeated this. After leaving the patient, the dressing became dislodged and the site began to bleed profusely.

'And it was when their partner came running down the corridor going "There's blood everywhere!"...And it's like the first time I'd seen that amount of blood just in one place. So that was a bit like Oh! [laugh] Yes, that was good!' (2J8)

Her evaluation of the situation as 'good' seemed to be based on the potential for developing future practice and gaining increased competence rather than how the patient might have evaluate the incident.

'Like I learnt, Oh next time maybe I'll do this, you know, apply more pressure to it [to ensure a clot has formed]. Make sure that they don't, you know, explain to them, Can you not knock your hand.' (2J8)

The story served as a statement of her status as new but also of her commitment to future development.

In the bridging section that followed, Julia suggested that prior to this experience *'I couldn't see myself in the uniform as a student nurse.'* She made clear the significance of a mental image for her own sense of self. Here the uniform is not simply work-wear but an important artefact (or prop) in the formation and performance of her identity (Rice, 2010). It was conceived as a vehicle for performing an expected attitude and establishing the expectations of others.

'I think the uniform was just, it shows professionalism...it signifies that you are a nurse...You know there's professional in your attitude, rather than what you wear...You should be professional even if you are not in your, erm, in your uniform.'
(2J8)

Julia used this incident to establish links between her experiences and her interpretations, creating herself a part in the drama. In doing so, she also performed and reinforced the values she considered essential for the learner nurse.

In a similar fashion to Beth and Denise, Julia talked about the generational differences between herself, her fellow students and the *'younger'* qualified nurses when compared to *'the older nurses [who] are what you call task-orientated now'* (after 2J8). There was an affinity with the more recently qualified staff who Julia perceived to value her contribution and were willing to support her learning. She characterised this as *'closeness'*, the context suggesting she was referring to age, shared recent experiences and attitude. She simplified the complex and diverse reactions of various staff by emphasising generational divisions and establishing her associations to order to achieve a sense of fit (Houghton, 2014).

'So it was, it was very different working with the different types of people. Erm, but it definitely, it made me think that the generations are changing very much.' (2J8)

Julia continued to broaden her affiliation by suggesting that this change was *'...what I like to see'* and that *'it gave it hope [laugh] for the Health Service'* (after 2J8). In her portrayal, Julia was telling herself into the future of the Health Service and, at later points in our discussion, telling herself into nursing (Jordal & Heggen, 2015).

Story 2J9 illustrated the act of establishing connections between prior experiences and contemporary clinical incidents in order to make meanings and tell herself into the nursing world. The story outlined Julia's negative assessment of a situation involving the post-

operative care of a person with learning disabilities. Unlike many people who might limit their movement to protect a surgical incision site, this person would walk around the ward causing the wound to bleed. Julia expressed her frustration at the inability of staff, and the ward sister in particular, to manage this without resorting to discharging the person *'because she was causing too much trouble'* (2J9). She was very critical acknowledging *'I did rant about it that night to my Mum'* and claimed *'my communication skills are definitely a lot better than some of the nurses [laugh]'* (2J9). Her own skills are contextualised by prior experience and enabled Julia to present herself as capable and confident in this and other aspects of care (2J11).

'...if I didn't have that experience of learning disabilities, I wouldn't have known how to go in there and talk to her. I wouldn't have. I would have been like the nurse.' (2J9)

Over the course of the story, Julia conveyed her passion and irritation. She acknowledged her own limitations in the past and that she now viewed herself as competent, in the process setting up the link to the next story.

In both 2J9 and 2J10, Julia expressed very strong and 'negative' emotions that connected her experiences, beliefs, judgements and were critical to her establishment of meaning (Zembylas, 2003). Recalling two incidents, Julia expresses dismay and disdain at what she perceives to be a lack of knowledge, skill and a constructive attitude. She shared examples of caring for a person who did not speak English and someone else experiencing dysphagia [problems swallowing]. Her unstated message was that 'if I have these skills, then surely existing qualified nurses should have these skills too'.

'I think that, erm, all adult nurses should have to do a course on disabilities as well. And maybe in the future it will change. Erm, and I think all adult nurses should learn sign language as well. I think it should be compulsory, even if they have to do four years instead of three years.' (2J10)

Julia was not only stating an opinion about the profession and the educational preparation, she was also emphasising her status as a stakeholder with a legitimate voice in the worlds of practice and education. At this point she was happy to perform and rehearse this in the comparative safety of our meetings and in her home environment with her parents.

Returning to the connection between past and present experiences, Julia told an exemplum that had the potential to be regarded as a paradigm case. Nehls (1995) asserts that stories about '*strong instances*' are paradigm cases when they enable a person to engage in a learning dialogue with their own understanding and knowledge (Benner et al., 2010, p14).

Having limited experience of caring for people living with dementia, Julia utilised the skills she developed before starting the programme to build rapport and a therapeutic relationship with a gentleman based on his previous military service. In doing this, she came to realise and value her existing skills and re-evaluate her attitude towards working with older people.

'Yes, that was interesting because I never really thought about elderly care before. But when I actually started working with some of the dementia patients, I thought, Oh I quite like this [laugh].' (2J11)

Underpinning this exemplum, communicated by way of tone, was that Julia viewed good practice as uncomplicated. She did not understand or have any tolerance for what she interpreted as a lack of empathy or willingness on the part of others. She implied that, from her perspective, the genesis of poor care is laziness, ignorance or both. Julia did not perform this as idealism, simply as being unequivocal.

Drawing again on her personal characteristics and beliefs, Julia recalled an incident in the university setting that she used to establish an explicit link between her sense of identity in the classroom and in the clinical environment. She portrayed herself as someone grounded in the realities of practice with an unequivocal perspective on issues which translated to her assessment of other classroom instances. She told of witnessing fellow students discussing the nature of family and how she felt '*shocked*' and '*disappointed*' as this degenerated into '*a full blown argument in the middle of the lecture theatre*'. Interestingly, she did not view this as a debate or a difference of opinion but as a conflict which caused her to feel shock and surprise.

'And I think, if you don't want to be here, leave, you know...I thought, how, you know, You want to be an adult nurse and you're acting like this...you're at university, you're not at school.' (2J12)

Witnessing this behaviour prompted her to question 'How did they even get on the course?' suggesting that she saw an incompatibility between the personal actions and professional values of her colleagues. Interestingly she retold parts of this story in 3J18, this time adopting a slightly more tolerant position.

In 2J13 Julia revisited the theme of 'the good nurse' originally storied in 1J2 but this time drawing on a more recent experience. She suggested that she had '*seen two different types of nurses*' (2J13). Once again she characterised the 'good nurse' as someone who had '*...got all her work done and she's gone in, she's sat and she's chatted to her patients.*' Julia reported '*it's kind of inspiring*' witnessing the practice of a nurse who was able to organise their time to achieve the objectives they set themselves.

'Well as a student, the stuff you're taught, most of it's not relevant to practice [laugh]. Because when you get into practice everything changes. The dynamics of it changes, you know, and especially time management...You haven't got fifteen minutes [laugh] to stand there. And I'm actually really lucky because I'm a student nurse, I get the time to go and talk to the patients.' (2J13)

Julia's role as a student provided her with a means of reconciling what she perceived to be conflicting demands and expectations. She portrayed her desire for patient interaction and made the explicit claim that her status allowed her to achieve this. Importantly this also enabled her to establish an affiliation and alignment with the 'good nurse' she described.

'And here [in the university] I have more time to think, erm, more time to think about what, think about practice, think about how I could improve myself, how I can improve here. But in practice, you don't have time to think.' (2J13)

In telling the story, Julia was not distracted by the fundamental contradiction of the position she established for herself. Having acknowledged the difficulties, she went on to make clear statements about her expectations of others.

'It's not, you know, it's not hard. And from what I can gather, the majority of the time all I've seen is nurses sat on the computers.'

At this point, her identity as a student did not appear to be conditional on the coherence of her story because a nursing student differs from a qualified nurse. This story represented a clear illustration of the dynamic tension between similarity and difference.

Julia attempted to emphasise critical aspects of her Student Nurse identity in the final story of our second meeting, retelling material addressed in 1J2 and 1J3. In this version of events (2J14), she challenged the apparent apathy and powerlessness among staff in a residential home and used the story to evidence her position as a student.

'...even now if I go in there and say Hello to her [a resident], she gets really excited because I'm about...And it was like, it was literally like, erm, my manager actually pulled me aside and thanked me because they said, You've totally changed everyone.'

With this as the outcome, Julia cast herself as totally focused on providing care, again with an unequivocal and uncompromising persona.

'I don't care [about upsetting other staff]. I'm there to care for people, I'm not there to make friends as far as I'm concerned.'

In this regard, Julia was rather atypical (Levett-Jones & Lathlean, 2008). While many students report taking active steps to fit in and belong, Julia's personal and academic identity as an outsider seemed very significant. It allowed her to represent herself as a *robust advocate*, a consistent thread in her personal, academic and professional identities.

Meeting in Month 8 the (Nearing year's end)

At the beginning of our final meeting, Julia offered an insight into her views about the critical aspects of a successful clinical placement, suggesting this might inform a potential career direction. Her initial focus was, as in previous stories, on the opportunities to engage in tasks and make a practical contribution. She acknowledged that this action is ideally based on knowledge and experience, telling the story of the community matron who enabled her to engage in activities that matched her perceived learning style and made her feel *'like a real student instead of just kind of someone watching [laugh]'* (3J15).

Julia told of how on a routine check visit, she and a community matron discovered a person whose condition had deteriorated due to the rapid onset of a urinary tract infection. She continued to tell the story with an evident narrative structure, including a crisis, resolution and resultant meaning-making. Julia recalled how *she* had negotiated the person's admission to a hospital bed, supported by the community matron who *'talked me through*

everything and then I did everything she would have done'. Julia indicated that it was her active participation in each stage of the process from the assessment and admission to liaison with medical staff that were the hallmarks of *'a really, really good learning experience'*.

'...you're supposed to be doing stuff and learning. Whereas, I find that when you're with certain nurses, they kind of see that as, OK you're learning, that means you observe.' (3J15)

Julia made the explicit claim that she had *'felt like a real student'* and that this was a *'breath of fresh air'*. Both were markers of the significance of this incident and the resulting story. Julia suggested *'it was definitely something I can remember'* performing a realisation about her own agency in the clinical environment.

'Err, I think from now I think, well actually, yes, we can do these things...Instead of just kind of taking the fact that, Oh no, you just watch this one. I'm kind of like, No, I want to do it. So it's made me stronger.' (3J15)

Details expressed within the story emphasised Julia's growing identity as a student of nursing. Her use of technical language and abbreviations relied on or assumes a shared meaning of language in context. She repeated phrases heard in practice which increasingly take on meaning as one becomes a nurse, often initially blended with everyday language.

'...and they had a massive UTI...So we called the doctor and we tried to get her a starbed because she just needed somewhere for the antibiotics to kick in.' (3J15)

Central to this story was the notion of permissions and boundaries and how Julia wished to present herself as someone actively and appropriately operating within these. The underlying crisis was Julia's lack of certainty over what she was permitted to do. It was notable as one of the few stories where Julia expressed any form of ambiguity or hesitancy, a situation she clearly found challenging.

'I think like, erm, because I didn't really know, like the university, they're great but they don't really tell you what you can and can't do as a student.' (3J15)

The matron was cast as someone who *is* certain and empowered Julia to act rather than be concerned with procedural boundaries. The consequence was that Julia could position herself as someone able to legitimately utilise her preferred 'hands-on' learning style and have a positive impact on the clinical outcomes for a patient. Having overcome this 'crisis'

she used the next story to perform her characteristically clear-cut perspective on practices that she deemed right and wrong.

In her very brief recall of an incident where a patient is transferred from their bed to a chair without using a hoist, Julia positioned herself as the antagonist, willing to resist the expectations and common practices of clinical staff even in her first placement. As the most junior member of the team, she represented herself as someone who, initially, was willing to exercise her resolve based on her sense of the 'rules' of safe practice. Ultimately, however she felt coerced into taking an action she believed was not safe.

'And I said, "But you shouldn't be doing that, you're taking his [weight]", and he was tall, he was like six foot odd. And I said, "But you're lifting his whole weight". And then, as it was, is there was three of us in the room and he, they stood him up and he fell...And they kind of force you into it. They're like "Oh yes but, you could just help lift, it's not really taking their weight."' (3J16)

In the context of our meeting, Julia was rehearsing her response to having limited power in such situations. She characterised her own position as conflicted, that she believed she knew how to act but was forced to 'break the rules'.

'And it doesn't matter how much you say it. "Oh yes but we do it this way". And I said, "But I'm not injuring myself, I'll watch and I'll support but I'm not doing it."' (3J16)

Julia was aware of the safe practice guidelines but felt she had been placed in a difficult position by powerful others. Novice nursing practice has been described in terms of the tendency towards rule adherence regardless of context (Benner, 1984). However, Julia sought to represent herself as knowledgeable and capable of decision-making but limited by the power dynamic and her perceived position within the clinical hierarchy (Cornish & Jones, 2010). It is a story in which Julia represented herself as uncompromising but made to comply. It represents the intersection of classroom and practice worlds and the much-reported dissonance that remains a common nursing student experience (Curtis et al., 2012; Wood, 2016).

The thread of distinction and difference between Julia and the permanent nursing staff was explored again in 3J19. This story involved the compilation of experiences prior to and since

starting the programme and included the retelling of stories 1J2 & 1J6 (from her time working at the nursing home). The incident concerned the contrasting working practices of registered and non-registered nursing staff and the demarcation, as Julia understood it, based on her previous experiences. A patient's call bell had been ringing for what Julia believed to be five minutes while she was engaged and not able to answer it.

'The healthcare assistants were busy and I said to the nurse, I said, "Oh that buzzer's been going for a long time". And she turned round and she said, "Yes, that's a healthcare assistant's job". And I just looked, I was like, "No it's not". So I went and answered it. I was like, "I'm so sorry!"....And I actually reported it to the ward sister. And I asked them, I said, "Is it everyone's job?" And she said, "Yes". And I said, "Well I think you need to tell some of your nurses that because they're under the impression that it's a healthcare assistant's job."' (3J19)

Julia continued to explain how a series of ward meetings were held and the result was that *'all of a sudden everyone was like, "I'll get that"'* [respond to a call bell].

An evaluation of the reported comments by Julia to the ward manager might suggest an atypical dynamic between a student and senior nurse. The tone is forceful, directive, candid and unambiguous. Alternatively, this may not have been an exact replication of the dialogue as it happened. Telling in this way allowed Julia to present herself as a catalyst for change and claim responsibility for raising issues with the ward manager who then set actions in motion that resulted in a changed atmosphere and attitude. Julia's sense of herself as fearless and passionate was reinforced in this story although she does also acknowledge her potential vulnerability.

'They had a massive team meeting and it was brought up a lot [laugh]...I think the health care assistants did actually name names. I didn't name names because I just said, in general. But I think the healthcare assistants did name names when they had theirs and then those nurses were brought into the office and said, Look, it's not acceptable.' (3J19)

The registered nurses were portrayed as less committed, perpetuating a culture of segregation between what they and the health care assistants did.

'You know, Ok, yes, you're all busy, we get that you're busy, but when the buzzer in the rooms behind you and you're sat on the computer, it's no hardship to just pop

your head in. So that did really annoy me, they just ignore it. They just pretend like there's no buzzer going off.' (3J19)

Julia was openly critical of those who are less actively engaged in the provision of physical care compared to the HCAs. She retained a very close affinity with her previous HCA experiences using these as reference points for her developing Student Nurse identity. Her image of nursing was closely linked with what a nurse does practically rather than intellectually. Unchanging in each of our meetings, she seemed keen to perform her personal and professional values informed by the traditional norms that '*valorise doing and task completion*' (Lipscomb & Snelling, 2010, p595). For Julia, at this point, workplace decisions were characterised as very simple and obvious.

Julia was, like an increasing number of nursing programme entrants, involved in a transition from HCA to student. This creates particular challenges for the individual including forced or intentional role reversal (Brennan & McSherry, 2007). A common strategy for managing what has been referred to as 'culture shock' is to revert to an HCA role which feels comfortable and secure even though this can restrict learning opportunities. Julia sought to resolve this by telling stories about her future self.

In 3J20 she proceeded to make the explicit and foundational identity claim, based on her experiences recalled in 3J19, that '*I'd like to be more caring than some of them [laugh], like personal care and that.*' Nurses that Julia talked of '*won't help people off the toilet, they won't help people off bedpans, they won't change pads or nothing...they won't even wash people*' (3J20). She identified that their reluctance to engage in these intimate care activities also restricted opportunities for building relationships. Unlike many of the previous stories that solely emphasised differences, Julia's central character in this story was a nurse who performed the function of an exemplar showing '*it can be done.*' This was one of the few role models in Julia's stories, an agency worker whose contract would typically not include ongoing responsibility for people's care.

'But they [regular ward nurses] just float around doing notes. And I'm like, every time I look at you you're on the same sentence you were five minutes ago. It can't be that hard when you're making notes on your handover sheet...I just think it's wrong there. So hopefully it will change soon.' (3J20)

She prefaced this story with a comment about how she valued experience over academic achievement.

'Whereas with grades, you could say, well actually, I got this, this, this. I know this, I've been taught this, but that doesn't prepare you for the real world. So that's why I did my two years caring experience before I came into nursing.' (3J20)

Julia's claim was that she made a deliberate choice even though previous stories suggest she needed to achieve the necessary entry criteria. She re-storied her past in a way that provided more congruent alignment with her identity at the time we meet. Emphasising her practical credentials and associations with an 'efficient doer' Julia was claiming her identity in the clinical context.

Julia conceived of her future self as a '*manager*' rather than a leader and performed an identity informed by traditional hierarchical, authoritarian and task-orientated characteristics. The image of her aunt as matron, recalled in 1J3, coupled with her claims of being uncompromising, fearless and resolutely focused combined in her performance. The degree to which Julia believed this of herself cannot be deduced from her stories. There was, however, a certain consistency in her claims that, in this context, may provide a thread that joins personal, professional and academic representations.

Coda

Julia's developing identity of herself as a nurse was informed by her enduring image of a 'good carer nurse'. She storied a limited number of reinforcing positive experiences, the characters in which might be considered role models (1J3, 3J20), and a large number of contrasting examples of adversity. Sellman (2011) describes the 'good nurse' as someone who '*genuinely wishes to enable the flourishing of more-than-ordinarily vulnerable persons* (p 177). All persons are vulnerable, yet Sellman suggests that nursing involves providing protection for those whose circumstances (physical, social or emotional) constitute an enhanced vulnerability to risk. Throughout our meetings, Julia conveys her appreciation of people's vulnerability by drawing heavily on her own experiences from school to emphasise the nurse she wishes to become and not become.

In stories 2J13 and 3J16 Julia provides an insightful illustration of the intersection between worlds of practice and education. Her emotions of frustration and dismay at the perceived contradiction act as the drive to author herself as a becoming nurse. Like other participants, authoring herself as part of the 'next generation' served the requirement to '*answer*' the world/s and establish a buffer composed of performed values and limited but developing agency (Holland et al., 1998, Peña-Talamantes 2013).

Chapter 9 -Discussion

Introduction

The preceding chapters represent the richness and nuance of the stories beginning nursing students told about their experiences in the context of research designed to better understand how they figure their identities during the initial stages of a pre-registration professional nursing programme. I set out to create an opportunity for the participants to narrate their identities through clinical, academic and personal experiences from their own perspectives, mindful that the act of telling was in itself an integral part of their identity formation. Detailed analysis revealed compelling tales, the use of various story genres and changing identity claims over time that warrants further discussion here. In the sections that follow, I will address each of the research questions.

Question 1 - What do beginning nursing student narrate as significant experiences, events and interactions during the first year of a pre-registration undergraduate programme?

The nature of 'significant'

Adopting a socio-cultural perspective assumes that the processes of identification are situated and purposeful, therefore can only be interpreted and understood in relation to the prevailing circumstances (Wortham, 2008). In earlier chapters, I have sought to locate the research within the relevant macro-level historical, cultural and political contexts. As a co-creator, I have articulated my own, personal and professional interests, motivations and prior experiences. Where possible, I have also provided contextual detail so the reader is able to appraise this significance.

Understanding that the story is not the experience itself but a partial representation, I considered how the participants chose what to story and what aspects they deemed pertinent to reify in this way. One aspect to consider is that of tellability; the degree to which a story is noteworthy and therefore worth telling. Rather than simply a quantifiable

function of the story content, tellability represents an evaluation and context-related negotiation. Uniqueness, novelty and humour form a lower threshold of tellability, whilst stories that embarrass or humiliate through personal exposure might exceed the higher threshold and therefore remain untold (Norrick, 2005). Tellers, mindful of the culture and context-specific conventions of storytelling make decisions about the worthiness and salience of events for reporting and what forms these should take (Baroni, 2009). Put simply, Polanyi (1979) suggests this becomes a response to “*What is worth telling, to whom and under what circumstances?*” (p207).

The initial *writing* of a story, in the form of application-supporting personal statements, afforded space and time for the participants’ considered response to these questions. They were able to craft the stories in their statements in order to enhance the persuasiveness of the account with the aim of securing a place on the nursing programme. Selecting a story to commit to a physical form was an acknowledgement that the events and experiences were, for that person, consequential, significant and related to their nursing aspirations.

In a similar way, the participants’ audio diaries represented those experiences they deemed relevant and noteworthy. These tended to be initial accounts concerning a *critical incident*. While definitions are limited, authors tend to agree that a critical incident, which may be a small or relatively minor occurrence, is experienced as demanding, challenging and comes to be seen as influential or transformative (Bulman & Schutz, 2013; Rolfe et al., 2011). Each of the limited number of diary entries described ‘demanding’ events and typically included the report of an emotional reaction. None were developed to the point where a reflective outcome was evident. Rather, they provided the teller with an opportunity to record an event that *may* be influential and therefore had significance.

These oral stories were the products of narrative thinking influenced by ‘*perception, thought, memory and imagination*’ and required improvisation in the act of storytelling (Kim, 2016, p156). Here improvisation is understood to be engaging in a creative process ‘in the moment’ rather than the thoughtless ‘mashing together’ of ideas. The participants told stories about what they perceived and could remember of an experience, what they paid attention to. Their particular experiences clearly impacted on what they were able to story,

reifying salient aspects as others are lost or omitted. As experiences were retold so new insights were shared, interconnections made and aspects of previous experiences were remembered and re-evaluated as significant. These stories have the potential to become what Boenisch-Brednich (2002) term 'key' narratives.

It is clear from this data that the participants were engaged in reflectively organising their experiences, events and interactions in order achieve meaning and integrity and sometimes coherence also. Early stories concerning historical events were told with clarity and confidence suggesting they had been shared and therefore rehearsed many times. Explored in more detail below, stories of more recent events contained elements, pieced together in the act of improvising that allowed competing and contradictory aspects to be performed without this jeopardising the integrity of the participant's story. As a result, I would claim that an objective evaluation of any event's significance is not possible. The act of storying located experiences in the life world of the individuals enabling connections and meanings. The significance of experiences, events and interactions were, therefore, dynamic as their relevance in the person's life story continually ebbed and flowed, strengthening and diminishing.

Events, experiences and interactions

Like all forms of communication, the teller has an objective, be this explicit and transparent or not. A clear example is the personal statements that sought to convince admissions tutors that the writer was the 'right sort of person' to become a nurse (Ding, 2007; Rankin, 2013). Consistent with the findings from various studies of students prior to entering nursing, there is evidence of a pragmatic orientation that foregrounds caring and altruism as anticipated and performed personality characteristics (Eley et al., 2012; Jirwe & Rudman, 2012).

The stories told most frequently during the initial meeting were life-histories. These autobiographies typically adopted the tone and pitch of the traditional "*once upon a time*" starting point. Each of the participants sought to create a storied bridge between what they regarded as professional and academic points of inception and their current position as a

Student Nurse. In the course of this, they also storied their choices and re-rehearsed their legitimacy and justification.

The two participants with previous higher education experience, Beth and Helen, chose to 'open' their dialogue with me through life stories or 'pen portraits' of themselves. Both sought to demonstrate the pathway they had taken to arrive at their current situation, legitimising their academic credentials and professional suitability. While they confirmed that they had successfully completed undergraduate programmes in the past, both represented the personal journey of maturing as people, admitting to mistakes and poor choices as well as subsequent actions that showed they had overcome adversities and made sacrifices. They also selected experiences to illustrate their understanding and embodiment of the ability to commit to, and care for others. Without direct clinical experience, both drew on examples of their previous personal and working lives to illustrate this and create a connection between their past, present and anticipated future. In the myriad of experiences that made up their lives to date, both Beth and Helen sought to illuminate what they saw as a series of interconnections that formed a coherent pathway.

Gubrium & Holstein (2009) stress the importance of these linkages in the process of meaning making. Connecting an individual occurrence to other events and interactions establishes it in the wider constellation of a person's life experiences. The way these links are formed and an experience's position relative to others dictate how it is understood and therefore its meaningfulness. They claim that '*no item of experience is meaningful in its own right*' (Gubrium & Holstein, 2009, p55). The act of storying these experiences, in the context of research focusing on professional identity, provided each of the participants with an opportunity to rehearse and articulate these links. In doing so past experiences, such as Beth's intervention with a sunbather (1B6), took on new meanings and altered significance supporting professional identity claims that could be presented to others (Bauman, 2000). Initially interpreted as an embarrassing situation where Beth wrongly perceived someone to be in distress, the retold story becomes an illustration of her commitment and concern for others even at the risk of ridicule.

Andrea, Denise and Julia employed a different starting point for their stories, recalling what they regarded as critical and traumatic events that not only illustrated why they had chosen to begin a professional programme, but also the sort of person they believed themselves to be. In each case, these were stories of existential challenge the participants considered were relevant to their emergent identity. For Andrea and Denise, the encouraging influence and confirmatory statements of a parent who subsequently died proved extremely powerful as critical and yet archetypal 'characters' in their stories (Booker, 2004). In both cases, they provided an almost 'mystical', guiding role that helped Andrea and Denise to see that the seeds of their hoped-for future were sown in their past, even though, at the time they were unaware of this. The notion of an ongoing journey is evident in their stories, however, unlike Beth and Helen, they were re-focusing on achieving an aspiration having previously been 'knocked off course' by life events.

Evidence from analysis of the data presented in the earlier chapters confirms that pre-service identities contextualise contemporary experiences for the beginning nurse. Experiences, events and interactions that pre-dated the formal start of a professional preparation programme were crucial to how these beginning nurses viewed and performed themselves (Adams et al., 2006). As examples, Julia consistently performed the service-focused orientation of herself as a health care assistant alongside her desire to challenge the stigmatisation of those with mental health and learning disabilities, while Beth's corporate outlook remained an influential feature of the nurse she presented herself to be as she sought to rationalise contrasting managerial perspectives in care settings.

Reflecting on the data also revealed evidence of similar plotlines and shared themes, which, given the demographics of the participants, is unsurprising. These corresponded with the plotlines evident in the interview data collected by Pearcey & Draper (2008). However, diversity and detail transformed stories about similar events and experiences into unique and personal '*key narratives*' (Boenisch-Brednich, 2002, p75). These are understood to represent important life events that are '*polished*' through repeated tellings/performances and which serve as '*personal and symbolic marks*' (Boenisch-Brednich, 2002, p75). In the course of developing one's professional identity, the creation of a compendium of such stories becomes important as '*go to*' accounts, not only of events but also as exemplars of

the person, their choices, actions, values and their perception of the social and cultural context; a Figured World.

Commonalities evident in the data included stories of caring, sacrifice and concern for others as a means of demonstrating the personality of the teller. Where the becoming nurse had recent, clinically relevant experience, this was offered by way of illustration.

Alternatively, and as was the case for three of the five participants, caring was presented as an extension of motherhood. In doing this, the person foregrounded values and behaviours closely aligned with the role of a mother and, by association womanhood, in order to represent themselves as someone already committed to the core of nursing. The threads of other aspects of their lives were woven into the early identities and while they were gradually replaced by other professional specifics stories, these principal motivations endured (Eley et al., 2012).

The gateway tales of novel experiences for the participants clearly formed the basis for many of the initial clinical practice stories. Dramatic, emotionally-laden events included exposure to the realities of illness, disease and disability, patients whose conditions deteriorated as well as new and unexpected relationships with patients and staff proved to be familiar storylines during the second and third round of meetings. Each participant told unique, yet archetypal stories about the consequences of relationships they had established as a result of their first clinical experience as a nursing student. In doing so they sought to establish a social affiliation and begin to compile their own collection of storied incidents with which to develop their professional identity.

During the latter stages of the data gathering period, the themes of stories shifted. In the second round of meetings, participants told of *'feeling different'*, with some openly asking *'Why am I here/doing this?'* The catalyst for such stories was a perceived discrepancy between the imagined world of practice, including the impression outlined at university, and the experienced reality. Stories concerning task completion (2A19 & 2J13) revealed the tendency towards 'rule-driven' practice that is typical of novice nurses (Benner, 1984). More concerning for the participants, is the difference in anticipated interpersonal behaviours. Even with limited experience or critical understanding, the notion of person-centred care

was promoted throughout the stories and discontent was expressed when this appeared to be lacking. In the final meeting common themes of growing confidence, resistance and improvisation were evident. In relation to the clinical context, participants told moral stories of right and wrong, positive and negative.

There are a number of potential reasons why participants might tell stories that could be designated as experiences of adversity. Firstly, it may reflect poor practices witnessed by participants. Unfortunately poor care practices are a part of some people's health care experience but that this is the majority of all care practices is incompatible with the evidence. Secondly, one must acknowledge the effects of tellability discussed above. Experiences of adversity have the characteristics of '*critical incidents*' and therefore have inherent tellability in this context. Accounts of poor practice told to anyone, and especially a nurse and nurse educator, will have an impact, hold interest (Polanyi, 1979) and draw forward emotions. These emotions operate relationally with identity (Harding & Pribram, 2009) and so form a crucial element of beginning nurse story-telling. Thirdly, adversity stories provide the opportunity to enact extremes of difference between the self and the other. The contrast with 'others' is used as a means of establishing distinctions between the narrator and those adjudged to represent the antithesis of normative, culturally accepted identity characteristics. Coincidentally the narrator also favourably emphasises their own image as a 'good' person and invites the audience to see them as a 'good nurse' (Alvesson et al., 2008). Lastly, the propensity to tell negative practice stories is a feature of the novice's perceptions of practice. Not only do extremes possess intrinsic interest, they provide an opportunity to observe the reactions of others and evaluate one's own interpretations. The stories participants told demonstrated their attention to the gross and highly visible instances that elicited strong negative emotions (3B17 & 2H7). By contrast, 'good' care incidents involve holistic, longer-term and often subtle interventions, characterised as '*thinking like a nurse*' (Tanner, 2006).

Novice vs Experienced

As I have already discussed, the initial triggers for the stories people tell are what they see, perceive and pay attention to. These are artefacts of insight, understanding and values.

Without insight, one may not perceive aspects of the situation and therefore be unable to integrate these into their stories. Research by Wilkes & Wallis (1998) and Wiman & Wikblad (2004) established that it is often easier to recognise non-caring than caring instances even when the respondents are registered staff. Benner (1984) suggests that a distinguishing characteristic of the novice nurse is their inevitable rule-bound behaviour which results from a desire to avoid mistakes or looking foolish given limited experience and limited conceptual understanding of newly learnt knowledge (Levett-Jones & Lathlean, 2008; Levett-Jones et al., 2015). They are typically attuned to notice the gross aspects of clinical situations and if complexities are perceived, they are often simplified rather crudely (Ben-Shahar & Schneider, 2014). By contrast, the proficient practitioner characteristically perceives situations holistically, cognisant of multiple perspectives. They are aware of the nuances that distinguish individual need and are able to employ subtle interventions to address these. The complexities of caring and the subtleties of the therapeutic relationship may not be perceptible to the novice and so do not form part of their storytelling landscape.

Revealed in the data is the idiosyncratic richness and diversity of the experiences, events and interactions that were considered significant. Some of these might be regarded as universally recognisable to any nurse either as a result of direct personal experience, through the recounted experiences colleagues or occupational folklore. In the act of telling, the participants contributed to the *'common body of saying, stories, beliefs, rites of passage (initiations, promotions etc.), and the like, that are not shared by non-members of the group'* (Keach, 1959, p573) and in consequence, *'told themselves into nursing'* (Jordal & Heggen, 2015). Individual and person-specific life stories were experienced and told in unique ways and yet identifiable commonalities were evident in the analysis of content and form.

Question 2 - What are the forms and functions of stories told by beginning nursing students as they develop their emerging identities?

Interest in performative storytelling as a feature of narrative inquiry, based on the early work of Goffman (1959), has been considerable (Kim, 2016; Squire et al., 2014) as researchers seek to explore the agency of stories through their personal, social and cultural effects (Squire et al., 2013). Storytelling enables members of social groups to achieve

visibility to others and, just as importantly given the focus of this research, to '*become audible*' to themselves by calling forth emergent identities (Peterson & Langellier, 2006, p179).

At each meeting and in each story, the participants were engaged in a performance. The act of storytelling, being a reciprocal event, involved both teller (narrator) and audience. Importantly, the audience included the teller themselves as well as other parties. Stories about our lives in the worlds we inhabit are performances of our preferred or favoured identities (Blackburn, 2010; Riessman, 2001). Even when the participants acknowledge and performed personal weaknesses, foibles or limitations, their objective was to persuade others of their preferred identity *despite* these impediments. These performances were more than expressions or representations but enabled the creation and re-creation of identities, '*embodied and socially-situated accomplishments*' (Iedema & Caldas-Coulthard, 2008, p6). This was achieved through the choices made by the teller concerning features including the lexicon, para-linguistics, emphasis and appeal to the audience as well as somatic elements of body language and gesture (Riessman, 2001).

Stories are, like identities, constructions created in historical, social and interactional contexts and express reflections, understanding and values. As a result of a detailed analysis, Plum (1988) suggested that, in casual conversations, each storytelling genre serves a specific social and rhetorical function, be this to communicate, entertain, persuade, or occasionally mislead. Beyond the actions of narrative and anecdote as 'entertaining' and exemplum told in order to 'make a point', my analysis of this data would suggest some more specific functions were evident when these forms of talk are used to consider experience and identity. Whilst an underlying tenet of analysis was to come to better understand the lived experience of the individual teller (Frost, 2009), consideration of different story types revealed various aspects of the participant's emergent identities as they constructed and reconstructed these over the course of our meetings.

Early stage analysis was conducted at a linear and structural level as a means of engaging with and organising the material through the use of well recognised and often used tools (Labov, 1972, 1997; Lambrou, 2014). Without the scaffolding framework of pre-determined

questions by which to deconstruct the outcomes of meetings between myself and the participants, I employed Plum's (1988) taxonomy of story-telling genres to establish bounded stories within the transcripts (See Table 4). These served as analytical units, initially considered rather discretely, but which later came to be viewed as connected and interconnected aspects of the continuing dialogue.

	<i>Narrative</i>	<i>Anecdote</i>	<i>Exemplum</i>	<i>Recount</i>	<i>Total</i>
Andrea	3	8	2	12	25
Beth	1	11	2	4	18
Denise	3	9	5	10	27
Helen	2	7	1	8	18
Julia	6	8	6	2	22
Total	15	43	16	36	110

Table 4: Summary of the number of bounded stories by genre

Many narrative studies have used as their starting point the ground-breaking work on black English vernacular by Labov (1972) who established the distinct and independent nature of a dialect through structural analysis of event narratives. Labov's (1972) six-part model has provided a method of structural analysis that has significantly advanced sociolinguistics . Strict application of the model does, however, result in large quantities of data being excluded for failing to meet the characteristics of a 'narrative' (*Abstract, Orientation, Complicating action, Resolution, Evaluation, Coda*). While some argue this ensures rigour in the selection and analysis of narrative data (Paley, 2009), for others, it fails to recognise and so undervalues the work of commonly-used but under-represented story-telling genres in identity research (Georgakopoulou, 2006; Patterson, 2013; Semino et al., 2014).

Developed from Labov's (1972) initial starting point, Plum (1988) delineated various 'narrative-type' storytelling genres including *narrative, anecdote, exemplum* and *recount* as well as *observation* or *comment*. Each is categorised by structural elements from which

speakers might deviate in the course of storying an event, returning to, repeating and restructuring in the course of a conversation (Eggins & Slade, 1997). The open invitation ('*Can you tell me a story about...?*') used to initiate both the non-directive meetings and the audio diaries was intended to allow participants to move freely through their experiences mindful that, in advance, it was not possible to be aware of what participants would consider meaningful (Trahar, 2009) .

Narratives

Unsurprisingly there were relatively few Labovian narratives amongst the stories told by participants (15 of 110 bounded stories). Julia told six, Denise and Andrea told three, Helen two and Beth just one. Each narrative involved a *complicating action* and an *evaluation* followed by *resolution*, these last two elements being the scarcest across all the stories told when understood to be discrete and bounded. Labov (1972) regarded the evaluation as the most crucial elements of a story, containing the drive and impetus for the telling as well as revealing the way the narrator relates to the narrative (Eggins & Slade, 1997). Some considerable rehearsal (and reflection) is needed if this is to project from the story itself and not simply be a deduction on the part of the audience/listener.

With the exception of Andrea, each of the participants shared a historical narrative account from a time before they started the programme. Beth's concerned her realisation of a shared worldview when undertaking her first degree (1B4). Denise told of her dawning realisation that looking and being professional was not the same thing (1D4) while Helen narrated her experiences of homelessness (1H5). Julie's initial narratives concerned her early experiences with health care quality (1J2) and her dyslexia diagnosis (1J4). Each contained a crisis situation that needed to be answered, prompting a transformative re-figuration of who the person was, how they saw themselves and wished to be regarded by others (Lambrou, 2007).

The narratives participants told related, in the main, to the clinical environment. While these contained a *complicating action* and *evaluation*, the intensity of the emotions expressed in the telling was noticeably less than in the anecdotes. While the situations were

no less significant, the cognitive processing undertaken prior to or during the telling involved an amelioration of their reaction to the events.

Interestingly, many of these narratives might be considered to involve 'typical' experiences for nursing students, recognisable and remembered by all nurses after their first year's pre-registration education. Active involvement in a traumatic situation and the sense of being 'a real nurse' (3J15), appreciating the boundaries of one's knowledge and skills (3H14), coming to realise professional (3D21), inter-professional (3A21) and changed family expectations (3J21) form key elements of the compendium of stories that inform the nurse's professional identity.

As cultural and social artefacts, like all forms of story, these narratives also had the potential to 'open up' Figured Worlds representing shared symbolic meaning (Riessman, 2008). Figured Worlds exist in the minds of people as well as in the images and media that surround us (Gee, 2014). For the analyst and the storyteller, the narrative provides a means of coming to understand the simplified 'as if' associations between people (actors), categories, interactions, practice and local discourses that are used to engage with the world without always having to build this from first foundational principles. The nature of the Figured Worlds of clinical practice and education inhabited by nursing students are examined later in this chapter along with consideration of the typical positional and figurative identities revealed in the stories.

Anecdotes

The greatest number of stories told had an anecdotal structure where a *Remarkable event* was followed by a *Reaction*. Anecdotes typically concerned novel, unfamiliar or unexpected experiences encountered by participants with the majority relating to clinical practice. These beginning nurses regularly found themselves in unfamiliar situations and used the anecdote to make sense of their experience through the performance of their reaction. The selection of a 'remarkable' event illuminated what participants paid attention to. While some of these might be regarded as mundane, the context and meaning for the individual made them significant (Peterson & Langellier, 2006). Andrea talked about acquiring a slow-

cooker to ensure she could manage tea-time for her children, negotiating the competing roles of mother and new nursing student (1A7). Helen talked about childhood games that she identified as a genesis of her social and political persona (1H2). In later anecdotes, the *Remarkable events* were frequently presented as a crisis or personal challenge. Witnessing suffering for the first time as a professional, exploring the nature of the nurse-patient relationship and openly disagreeing with the observed practices of others were all storied as anecdotes. While these experiences were not resolved to the point where explicit learning was acknowledged by the teller, they represented an important contribution to the compendium of storied experiences from which they could negotiate and construct their professional identity.

A particular function played by the anecdotes told as part of this research is as media for communicating emotion. As a rhetorical and representational device for reconciling competing and conflicting identities, the workplace anecdote creates an interface between personal and public or professional (Holmes, 2006). Frequently this was accompanied by a description or demonstration of the emotions that acted to both drive the anecdote and cement aspects of its performance in the minds of the teller and audience.

An analysis of the emotions conveyed here revealed, rather discouragingly, a tendency towards the 'negative' or uncomfortable. Stories of anxiety, frustration, disillusionment and anger far outnumbered those of joy, satisfaction, happiness and contentment. The use of a writer's wheel to accurately label emotions revealed a feature of English language that may partially explain this. There are approximately 25% more words to express negative than positive emotions (Tausczik & Pennebaker, 2010). When combined with a beginning nurse's limited perception of the subtleties of expert practice, discussed above, we may be approaching an explanation for the nature of the stories that were told here.

An alternative interpretation is that the emotive nature of anecdotes was a consequence of 'moral distress' (Sasso et al., 2016). Challenging interpersonal relationships with clinical supervisors, failure of person-centred care and personal characteristics of the individual, frequently elicited an anecdote. The participants re-storied instances of dissonance and inconsistency between deeply held values, anticipated or hoped for realities and their

perceptions of their own experiences. These manifest in strong emotions that are likely to inform future care actions, identities of the self and of the profession as a whole. Along with values, emotions played a critical role in how the participants performed their identities.

Exemplum

The identifiable characteristic of the exemplum was its moral message about the academic and clinical worlds and how they should be in the eyes of the participants. Some told only one or two (Helen, Andrea and Beth) throughout the entire data gathering period while others told five or six in total (Denise and Julia respectively). Plum (1988) suggests that, unlike the narrative and anecdote both of which represent events as problematic, the exemplum is more of a social and moral comment constructed around a culturally-specific incident. The act of moralising has, in contemporary contexts, attracted negative connotations, however hearing and telling moral-laden stories (or parables) must have a place in professional education if students are to be critical of assumptions and accepted practices.

Given the open invitation, Helen and Beth occasionally made comments and expressed opinions. As these are storytelling genres, they were excluded from the detailed analysis but provided an opportunity for these participants to rehearse viewpoints. In telling them, they may have sought a reaction which I was careful not to provide, in the context of this research study.

By contrast, Julia and Denise expressed their judgements of right and wrong. Both were unambiguous claiming not only how they saw the world but also proclaiming how it *should* be. Julia boldly emphasised what she saw as the critical importance of a person-centred approach to care. Rather than focusing on the pre-requisite characteristics of professional practice (such as courage, care, communication), she simply viewed poor levels of knowledge and practice as unacceptable (2J11). This unequivocal standpoint was performed consistently throughout the meetings and may have been a feature of her relative youth or the idealistic expectations often placed on nurse leaders (Dyess et al., 2016). Denise demonstrated a slightly more considered assessment of how to manage the limited support

offered to newly qualified staff (3D23) but was equally clear about what she saw as unacceptable. As a result, exempla served the purpose of not only prescribing appropriate behaviour but also demonstrating values and beliefs about the culture as it was understood by the teller.

Each exemplum provided an opportunity for the participant to evaluate their own perceptions of practice against normative standards, often serving as a space for enacting moral resistance (Peter et al., 2004). Embedded within these exemplum were images of the ideal professional identity, the image of oneself that is desirable and aspirational. This forms an important aspect of the dynamic development of personal [and professional] identity (De Ruyter & Conroy, 2002). With limited first-hand experience and therefore a dearth of role models, the early image of the ideal provided becoming nurses with something to strive towards. In the course of their first year, each of the participants experienced dissonance as they searched for values within the community that resonated with their own. Numerous studies have identified this dissonance between the 'idealised' view nursing students have on entry and the realities of practice as a work environment (Curtis et al., 2012; Lipscomb & Snelling, 2010; Melia, 1987; Wood, 2016). The exempla provided an important opportunity to evaluate, rehearse and perform the values underpinning their image of nursing, other nurses and their own professional identity at this early point in their becoming.

Recounts

Recounts were the second most commonly used story-type making up 36 of the 110 bounded stories told. As a temporally sequenced record of events, they contained the simplest of structural characteristics and yet frequently they revealed the teller's subjective attitude towards their experiences (Eggins & Slade, 1997; Lambrou, 2007). In narrating her early life story, Helen recounted ambivalence in her decision to move away and study her first degree, the opportunism of a job working off-shore and the destabilising effect of becoming homeless. Given the opportunity and the context, all of the participants outlined instances from their lives which they believed to be of relevance and interest. Each of the participants provided recounts that established their personal and social histories and represented conscious choices about what to emphasise and omit. As a result, each recount

served as the performance of connections enabling the person to represent themselves in a preferred way as part of their ongoing storied life.

Importantly, the participants used the recounts as an opportunity to recall and organise events, practise their use of newly acquired technical language in context and demonstrate they had experienced events that might be regarded as typical for a nursing student (passing an academic assignment and collecting results, working with challenging patients and staff, engaging the support of fellow students and experiencing the mundane aspects of clinical work). In addition, the recounting of events revealed how they had been appraised and evaluated. Unlike narratives, the evaluation in these recounts is often ongoing and accumulates over the course of the story rather than existing as discrete and identifiable clauses. Eggins & Slade (1997) suggest that the purpose of the recount is to tell how events are linked. Frequently, the recount allowed the participants to shift from one storyline to another. In doing so, they provide an opportunity for the analyst to observe the associations considered important to the teller/narrator. Therefore, recounting rather than simply recalling events acted to shift from the event as fixed and historic to the more temporality fluid 'experience' which the participants actively performed.

The therapeutic act of telling

The capacity of storytelling to achieve therapeutic aims has seen it employed effectively in psychotherapy practice (Bergner, 2007). The act of articulating experiences and the problems, challenges and traumas that are ubiquitous aspects of everyday life has recognised potential as an arena for re-authoring and meaning-making that enables a person to better understand themselves and their circumstances (Habermas & Berger, 2011; Lambrou, 2014). Telling one's own stories provides an immediate, although often temporary, remedy to the experience of dissonance or social and personal incompatibility. The interviews and audio diaries provided an opportunity to rehearse and reconfigure what the participants perceived to be trials or obstacles, enabling a degree of catharsis, giving a voice and a space for identity claims.

Question 3 - What are the identity claims that beginning nursing students make? How do these change as they progress through their first year of a pre-registration undergraduate programme?

Identity claims are speech acts that concern who the person is and what they do. In practical professions such as the ministry, social work, teaching and nursing there is a tendency to draw on an evidence base that not only underpins 'what to do and when' but also 'how to be'. Beginning nursing students are required to navigate the dilemmas of *acting* and *being* in ever-changing settings. Longevity and experience provide an accumulating number of opportunities to enact identities such that they acquire a level of durability rather than solidity. Any beginning professional is faced with resolving the *acting* and being dilemma. This is the transformative nature of 'becoming', an iterative and continuous process involving, not only their epistemology but also their ontology (Sandvik et al., 2015; Scanlon, 2011).

I would argue, based on the evidence presented here, that the start of the programme simply represents the formal and named start to 'becoming a nurse'. The stories recounted by the participants in this research would suggest the genesis of the process of becoming is far earlier than the formal starting point. Taking the often used metaphor of woven threads combined to create a rope, one might consider the point where the addition of a thread that becomes entwined represents the point where becoming 'as a nurse' is formally recognisable by others, but this is far later than the point where the becoming nurse is aware of themselves as a potential nurse.

Each of the participants, in this study, portrayed a representation of themselves from their past as a counterpoint to the contemporary way in which they wished to be seen. Denise was the 'dedicated mother and daughter' experiencing a sense of liberation and opportunity. Julia represented herself as a 'victim' who had become a passionate advocate for those who are oppressed, while Andrea similarly cast herself as formerly disempowered and was now emerging as her more authentic self. These were very different starting points to Helen and Beth who had both experienced Higher Education in their late teens and twenties. Both cast themselves as the 'wild child' who eventually settled. Beth was the

‘corporate woman’ who had developed a greater social conscience while Helen was the ‘dedicated worker’ who avoided burnout.

In many of the pre-clinical stories, influential characters were identified and there was clear motivation to either emulate or honour as a way of enacting their identity. In doing so, each participant was making an identity claim about themselves by suggesting *‘I have a sense of responsibility to the past and a sense of duty’*, *‘I am true and honest’* and *‘I am capable’*. Without being able to call on specific practice experiences, some of the participants employed syllogistic reasoning in order to establish a connection with their past and present selves. Denise provided the clearest example of this when discussing the importance of coping which clearly informed the nature of professional identity and the figured world of practice. Denise’s reasoning was that in a challenging situation (Road Accident- 1D2), she was able to cope; nurses are expected to cope; therefore she has the capacity to be a nurse. Each of the participants employed this form of reasoning and enacted it within their storytelling as a means of showing both themselves and their audience, the characteristics they regarded as important.

Andrea

The streams of identification for Andrea were influenced by her personal, professional and academic experiences prior to starting the programme. Professionally her identity claims revolved around an increasing association with health care staff and the organisation (NHS) in general (2A15). Her initial claims reinforced the view of herself as caring which began to transform into a view of herself as capable. Admitting her own naivety in some early stories (2A12 & 2A16) she claims her position within the nursing team through an association with HCA’s more than registered nurses. Alongside this, her association with and desire to defend the health service forms a more clearly articulated theme in her identity claims. As a learner and a person, Andrea is significantly influenced by her performance and her dyslexia diagnosis. Over the course of our meetings, Andrea makes a very explicit claim of her own resilience in various aspects of her life, a claim that she uses to re-interpret her past and frame her future.

Beth

One of Beth's most transformational stories also concerns resilience (2B7) and illustrates how her identity claims developed over the course of the first year. Initial stories to represent herself as a 'good person' were performed alongside self-disclosures that were intended to demonstrate a realistic and unbiased self-assessment. As any identity performed is that of a preferred identity (Blackburn, 2010; Riessman, 2001), the bias will always act and it is the function of the analyst to attempt to uncover this.

Beth was unsure about her career choice at the beginning having switched from a primary education course at the eleventh hour. As a result, her early claims focussed on suitability. It was not until our second meeting that these claims had 'clinical' substance and Beth performed herself as a person better able to see past another's illness because of her new knowledge and insight (2B7).

Beth's claims during our second meeting were heavily influenced by the views of her husband. In the face of her own ambivalence, she appeared to rely on his reassurance about her own excitement and commitment. In our final meeting, the claims are much more about difference and separation especially when compared to other participants. Claims of closeness and affiliation with colleagues were to enable access to information and not as a basis for an ongoing professional identity (3B19).

While the data gathering and analysis occurred simultaneously, it is challenging to resist interpreting Beth's collected stories in light of her sense of a failure to 'fit in' and ultimate withdrawal from the programme. Resisting a simplified causal link between dissatisfaction and discontinuation has demanded that these stories be considered for what they revealed at the time, rather than as an explanation of the past with the benefit of hindsight.

Denise

Characteristically, Denise's early stories contained claims of right and wrong. These related to her personal life and the way she chose to bring up her children (1D3), her view of other nurses (1D4 & 1D6) and how she authored her future self (1D5). Her early successes in the

academic aspect of the programme are claimed with an air of mild embarrassment. Denise's endeavours resulted in achievements that she felt would disassociate her from the rest of her cohort and so were downplayed in the very act of being celebrated. This tendency was consistent throughout the data gathering period. She managed this by developing associations that favoured individual personal affiliations over *'being part of the group'*.

Clinically Denise's identity claims showed a balance of tolerance and challenge which could be characterised as 'picking one's fights'. Passivity and acceptance of the student's position in the hierarchy, along with an unsurprised acknowledgement of the 'apprentice's' role were contrasted with stories of herself as improvisational and provocative. In the analysis of Figured Worlds, these improvisations are considered a predominant form of agency (Bourdieu, 1977) and an indicator of power dynamics and emancipatory actions (Holland et al., 1998) but, most importantly, they were a mechanism by which the participants engaged in creative iteration rather than slavish re-production (Deleuze & Guattari, 2004).

Helen

Unlike some other participants, most notably Julia, Helen consistently performed her uncertainty over her choice to become a nurse in spite of it being a long held ambition. Helen re-storied part of her childhood to demonstrate the enduring nature of her desire to be a nurse (1H1) and the discouraging and stereotypical views she believed she had to overcome (1H2). In doing this, she claimed commitment, dedication and tenacity but not in a blind and unconsidered fashion. Each of these claims were restated in stories about her role as a public service manager, effectively establishing the link between her past, present and anticipated future selves.

During our second meeting, Helen's identity claims increasingly evidenced her anxiety and uncertainty. In her previous role, she viewed herself as dynamic and willing to advocate strongly for clients. In the clinical context, she became angry with herself for failing to intervene (2H7), embarrassed at being overwhelmed by new experiences (2H8a) and hesitant when it came to establishing the unfamiliar nurse-patient relationship (2H8, 2H9 & 2H11).

By the final meeting, Helen's claims were actively used to achieve and maintain a discernible distance between how she saw herself and the image of the nurse she was creating by her experiences. Admiration and a desire for technical knowledge and skills were set against the fundamental self-disclosure when Helen suggested '*So seeing myself as a nurse, I don't know, I just really want to do it*' (3H14). This represented the tension between similarity and difference that was evident in many of the participants' stories.

Julia

Julia's identity claims revealed an unambiguous view of the world and of herself based on the relatively recent traumas she had experienced. These significantly informed her personal, academic and professional identities. Being bullied at school, overcoming a dyslexia diagnosis and challenging observed poor practices in a nursing home were linked through her stories. They were used as evidence of her ability to embody the professional nursing values of courage, commitment and care. These were identity claims that Julia made consistently throughout our meetings and which informed the certainty and stability she created in the fluid context of her experiences as a nursing student.

Julia seemed to draw strength from viewing herself as an outsider, able to proclaim on the observed actions of others (3J18). No longer a 'victim' and without power, Julia portrayed herself in her own stories as a 'fighter' and related this to all aspects of her current and future experience (1J4 & 2J14). She was the only participant who explicitly storied her role and vision for the future based on an apparently unwavering commitment to the 'core values' and a moral certainty that exceeded that demonstrated by the others.

Emergent commonalities

While I have not set out to conduct a thematic analysis, there are broad commonalities evidenced in the identity claims made by participants and how these changed over time.

Caring

At some point in each of the meetings, the participants claimed to be caring. Initially these were morally configured and based, in the main, on altruistic values. Embedded in many stories were the claims that the participant cared about people and this was innate. In doing so, they reinforced the notion that caring was considered the normative dimension or pre-eminent value for a nurse and critical to their sense of professional identity (Apesoa-Varano, 2007; ten Hoeve et al., 2014). For each participant, it served as an early identity marker, establishing a link between their past, present and anticipate future identities (Baxter, 2011). As a result, it has been suggested that caring is a threshold concept for the becoming nurse, requiring movement from simplistic and common-sense conceptions to more complex notions that may be fragmented, contradictory and evolving (Clouder, 2005). For some, realisation that caring as a professional was more than the application of a personal characteristic in a clinical setting ranged from mildly surprising (2A12) to fundamentally upsetting (3B16). These participants seemed to manage this by making claims to be different to those nurses they worked with.

Differences and similarities

Interestingly, a significant number of the stories told by participants concerned how they were similar to or different from those with whom they were working and studying. For most (Andrea, Beth, Denise and Helen) affiliations in the academic context were established early but then became more selective as they made claims about being part of a sub-group. As mentioned above, Julia maintained a separation in each of her affiliations throughout the first year.

In the practice setting, rather than a pattern of establishing increasing similarities and attempts to mimic these, many of the participants established distinctions between themselves and significant 'others' acting in the field (Bleakley, 2011). Establishing the contrast and difference between the way the participants performed themselves and the role they cast or positioned others achieved two results. The first was a node or point of intersection in the permanently labile process of identification. The second was to exercise agency or control in situations of relative powerlessness. Casting others in a particular light

within their own retold stories provided a means of control that enabled the person to perform and claim a preferred identity.

Resilience

A consistent feature of the preferred identity concerned the ability to cope and be resilient. For many participants, their perception and performance of an ability to cope, embodied what it was to be a 'real nurse' (2J8), an essential self-perception as students progress through their programme (Anderson & Kiger, 2008). Most of the participants told stories about coping or not coping, the majority concerning clinical practice (1A6, D9, 2H8a). The significance of a nurse's ability to cope, to be resilient in the face of competing organisational, technical, professional and academic adversities, as a feature of professional identity raises a particular challenge. A nurse who performs their capacity to manage complex and changing situations will view themselves and others as a capable professional (3J20). Situations that exceed the ability of a nurse/nursing student to cope not only make demands that cannot be managed but simultaneously cause the individual to recast their view of themselves resulting dissonance or crisis (2D14, 2H7).

Here we enter a rather cyclical relationship as these stories of coping represent both tales and acts of resilience. Formed into a story, the participants made claims about the nurse's ability to cope in the demanding milieu of health care and their own capacities in this respect. As 're-presentations' or 're-experiences' (Goffman, 1981), they provided a mechanism for achieving resilience, where participants employed various strategies including reflection, re-positioning and emotional evaluation (McDermid et al, 2016).

Agency

As they progressed through their first year, there was a consistency in the increasing claims of agency through improvisation. Holland et al. (1998) consider these '*moments of resourcefulness*' to be significant ways of renovating the cultural landscape. Denise drafted and anonymously posted an article on nutrition (2D15), while Beth and Andrea improvised ways of working with senior colleagues (3B13/15, 2A21). Increasingly participants made opportunistic use of the available resources to affect their position in the 'cultural game'.

Through stories of 'resistance' the participants were able to make identity claims that emphasised their agency even in a hierarchical context that afforded them very limited positional power.

Fitting in

At the point of graduation, fitting in to a clinical team serves an essential social and emotional function with significant psychological, professional and financial consequences (Malouf & West, 2011). However, as nursing students, the participants did not view themselves as part of the team and neither, it seems, did many of their mentors. This situational self-positioning, as well as the positioning by others, informs the negotiation of fit and belonging (Kraus, 2006). The stories suggest that the participants occupied and owned a peripheral position (2A19, 3D24, 3J20), enabling them to create an identity of difference in the clinical setting, sustainable because of their fit as part of a student group. This was characterised by most of the participants as being part of the 'next generation'.

Generational change

Many of the participants made explicit claims to being part of the 'next generation', an identity marker that enabled them to hold in tension their identities as nursing students operating in contrasting worlds without descending into crisis. Denise reports this phrase being used by one of her lecturers (2D10) but it is evident throughout the stories told as the participants established their becoming identities. Embodying a 'new generation' of nurse allows an individual access to a shared cultural history by association. It enables individuals to create a bridge to the future from the very early stages of their professional lives, at a point even where their experiences are extremely limited. It creates affiliations with others at a similar point in the process of *becoming* without requiring that experiences are identical and yet it does allow for the gradual formulation of a compendium of stories that will be recognisable to others and serve as affiliational resources. Conceiving oneself as part of the 'next generation' means individuals are not required to accept responsibility for the actions and outcomes of current and former nurses. It does, however, enable a new nursing student to contemplate and begin to shoulder the responsibility for the profession in the future without this having a crippling and incapacitating effect. As a result, over the course of their

first year, these participants moved to a point where they regarded themselves as representatives of the next generation of nurses.

Question 4 - What are the Figured Worlds beginning nursing students inhabit?

Historically nursing students have been required to operate in and inhabit two very different and yet intersecting worlds of education and practice balancing the role of learner and worker (Melia, 1987). The situation reported by Melia in 1987, rather disconcertingly, still endures today (Wood, 2016). The general responses of the participants suggest they experience this tension as competing roles. In spite of attempts during data gathering to gain insights about the participants' education experiences, this world was under-represented in the stories told to me. In these circumstances, I have provided a brief account below of the Figured World of the nursing student but am suitably cautious of simply creating the world from my own experiences. By contrast, I was regaled with numerous colourful, evocative and sometimes disconcerting stories of practice from which it is possible to deduce the Figured World of the Student Nurse.

It is evident from their stories that each of the participants had developed a generally consistent image of the 'good Student Nurse' predominantly in terms of practice behaviours represented by a keenness to participate and facilitate 'doing the work', willingness to 'muck in', awareness of their junior position and grateful for time and information from practice staff. Less evident was the image of the 'good nursing student' in terms of learning behaviours (seeking clarification and explanations, actively linking theory and practice, offering respectful challenges). Across the data, these comprise and contribute towards two competing 'typical stories' (Gee, 2014) that along with artefacts and characters, open up different Figured Worlds in which the participants operated.

The Figured World of the 'nursing student'

The role of lecturers and tutors as principal actors in the university setting seems to be unsupported by the stories here. They may represent the power of the institution to teach and assess, but it is relationships with fellow students that initially embodied the process of developing understanding (e.g. 2D16 and 2A17). Those who had previous higher education

experience performed an awareness of and a confidence in their abilities to successfully engage as classroom learners (Beth and Helen). Julia claimed her 'status' as a good student by her extended and self-imposed library induction (2J7) and Denise through her revision practices (3D26) and her rejection of stereotypical student behaviour (3D27). In each case, the participants inherited and subsequently participated in some of the pre-existing discourses of higher education.

Critical actors in the Figured World of the nursing student were other students in the same cohort. Being based at a satellite campus, the participants had very little contact with students on other programmes. As a result, the position of the dedicated student involved diligent and active engagement in the classroom and simulated practice environment, as well as the expression of values including patience, open-mindedness and respect. Significance is applied to preparation for an occupational role rather than the study as an intellectual activity. Achievement in assessments was a measure of successful learning behaviours rather than an indication of criticality. In addition, the Figured World of the nursing student represented, for these participants, a 'safe' environment where they were surrounded by like-minded fellows undergoing a similar experience.

The Figured World of the Student Nurse

The cultural phenomenon associated with clinical practice draws heavily on the historical relationship between the users and providers of public health care in the UK as well as the culture within the nursing profession. The former valorises not only the providers but also the services they offer. While recent high-profile occurrences including the events in North Staffordshire might have subjected this relationship to more detailed and critical scrutiny, there remains a favourable public view of health care workers as dedicated, knowledgeable and trustworthy experts. Early stories from participants illustrate how this public image infused their own identities.

The Figured World of the Student Nurse was heavily influenced by the legacy of apprenticeship. Ward sisters, matrons, and doctors were critical actors embodying the hierarchy that was reinforced and reproduced across varied clinical and non-clinical settings.

In some instances (2H12) the individual was buffered and protected in their role but in most cases, the Student Nurse was expected to learn experientially. 'Simple' caring tasks could be viewed as necessary just to address the practice priorities of completing the workload. At times these were viewed as the inevitable consequence of being the most junior staff member. In contrast, unfamiliar, technical acts (dressing wounds, removing venous access devices, giving medicines) were valued by students as markers of being a real nurse, but access to these, perceived to have cultural capital, were restricted by mentors.

'Being professional' was valued and closely associated with the ability to cope with emotionally challenging situations. The early Figured World of the Student Nurse was populated by qualified staff who they believed could 'deal with' complex situations. This influenced their initial sense of self. Simultaneously, repeated social encounters with 'patients' revealed the need for a new way of relating. During the initial phases of their professional preparation, the Student Nurse related to patients on a social level but increasingly came to appreciate that an alternative multi-dimensional approach was required.

People never inhabit a single Figured World (Holland et al., 1998). In their illustration of the characteristics of Figured Worlds, Holland et al. (1998) claim they are *'processes or traditions of apprehension which gather us up and give us form as our lives intersect them'* (p41). While the image of being 'gathered up' includes notions of support and protection, the tales of these participants describe the rather more perilous experience of being 'swept along' as they establish their agency and emerging positional and figurative identities.

Question 5 - How do beginning nurses go about figuring their identities in these worlds?

At the outset, each of the participants sought to establish connections between their past experiences and what they understood to be the image of the professional nurse. While the societal image was evident in some of the stories told, this was frequently combined with personal experiences to add colour and detail. More influential were the examples of care and concern for others that each participant promoted. Clearly, each person had a pre-

existing image of themselves as a nurse but lacked the compendium of stories that enabled them to perform this as a legitimate role. Each participant, having a unique personal history, found themselves in a position of tension, keen to hold fast to connections and meanings from their past whilst simultaneously shifting to achieve a new transient stability in the novel social and cultural contexts of education and practice (Iedema & Caldas-Coulthard, 2008).

Their engagement with the Figured World of the nursing student was significantly influenced by previous educational experiences and, while new, contained elements and roles that felt familiar. Each of the participants was successful in meeting the academic requirement of the programme and so this world was typically represented as unthreatening. By contrast, immersion in the Figured World of the Student Nurse exposed the participants to unfamiliar opportunities and threats about which they created key narratives, anecdotes, exempla and recounts in the process of identification.

Within these stories, they often positioned themselves and others in order to represent a favourable and caring self-image. Embodying professional values, 'rescuing' patients, resisting poor practice and representing a 'new generation' were recurrent themes in the stories told. Identities were performed in the immediacy of the incident and then reconstructed in the narrating of the incident. The experience of the nursing student, required to engage in and alternate between various academic and practice settings; establish, terminate and re-establish relationships with patients, supervising health care professionals, fellow students and tutors; acquire and apply knowledge and practice skills in shifting contexts, emphasises the fluidity of cultural-historical systems and the fiction of stability.

With experience, a person accumulates reoccurring opportunities to enact identities as well as developing a will and desire to enact them in an increasingly diverse range of circumstances (Iedema & Caldas-Coulthard, 2008). Each incident had the potential to become a key narrative. In the performance, each participant made unique identity claims and authored themselves as they preferred to be, into the nursing collective.

During the initial phase of their professional preparation, these participants were yet to engage in the act of world-making, the final context of identity. They did, however, begin to story their imagined future selves as potential nodes of connection between their interpreted past and anticipated future. From a post-modernist perspective adopted here, identity is the product of assemblages, the connection of disparate elements drawn together in the act of storytelling and performed to the self and others, in this case me. Identities were performed in the instant and subsequently storied during our meetings, as audio diary entries and the innumerable casual conversations the participants will have had with family, friends, colleagues and tutors. Each of these afforded the opportunity to revise, re-purpose and refine the story for the audience and also for their own self-image as they took the early steps in the ongoing process of negotiating their identities.

Conclusion

This chapter has drawn together the analysis and interpretations of 110 bounded stories told by participants in order to address the research questions. While beginning nursing students might share common experiences, the stories themselves are unique and contribute to the teller's sense of self. The various forms or genres used revealed layered perspectives about these experiences, how they were interpreted and how the teller wished to present themselves. By analysing identity claims and how these changed over time, it is apparent that initial personal claims remain durable and are supplemented with defining statements associated with the worlds of university education and clinical practice. I have begun to describe the Figured Worlds of the Student Nurse and of the nursing student, complex worlds that intersect and provide a context for establishing agency as well as emerging positional and figurative identities. Influenced by the artefacts, people and discourses, each participant actively storied themselves into the nursing collective in a way that retained their original sense of self while accommodating the novel worlds they had recently entered.

Chapter 10 – Reflections on my contributions to knowledge and recommendations for development of practice and further research

Introduction

Drawing generalisable conclusions from data provided by a small number of participants requires appropriate caution. At best it may be possible to suggest '*fuzzy generalisations*' (Bassey, 2000) although I am uncomfortable that these should have any predictive facility. However, the rich repository of data gathered and discussed in the previous chapter enables me to make a justified contribution to knowledge concerning how beginning nursing students develop their identities during the early stages of a pre-registration programme. These represent my reflections, at the end of the inquiry process, as a nurse educator-cum-researcher. They are divided into four parts and relate to learning resulting from the storied data, learning from the narrative inquiry research process, insights on supporting nursing student development and methodological contributions. Having explained these and made suggestions concerning future educational practice I will consider potential areas for further research.

Reflections on the storied data

It is evident from the data that beginning nursing students do not start their professional preparation as blank slates. They enter pre-registration programmes with a pre-existing, if rather rudimentary sense, of what it is to be a nurse. These are often morally configured understandings drawing significantly on the individual's personal values that are predominantly influenced by their prior experiences in, or related to, health care contexts. To a lesser extent, societal and cultural images of nursing also influence what they believe a nurse is (or should be) and therefore what they anticipate becoming. During the first year of their professional preparation they experience a number of novel situations. Many of these are interpreted as challenging particularly those that concern being a nursing student in the clinical practice setting. This is especially so when early images of nurses and nursing are

mismatched with the experienced reality. In these situations beginning nursing students story their experiences and accumulate a compendium of readily available accounts.

This research gathered, from a small group of individuals, rich and detailed narrative accounts of beginning nursing students. They are not sanitised or objective. As a result, they illuminated the contemporary experiences of those at the point of entry to a career in nursing, even though one withdrew, and highlighted some of the challenges they face.

I suggest that educational methods that actively employ students' stories, value them, encourage and draw them out, provide an antidote to the competence driven nursing curriculum. It is a means of focusing attention on the human experience and representation of the student as a means of uncovering 'taken for granted' thinking to evidence and encourage a sense of knowledge creation on the part of the nursing student (Walsh, 2011). The use of narratives provides a complementary means to aid students' understanding of the complex nature of holistic care going beyond technical competence and sound knowledge to approach phronesis. Narrative pedagogy represents a well-supported mechanism for educational transformation and a means for helping students (and educators) to question their understanding of nursing and themselves as people and nurses (Ironsides, 2015).

In nursing's competency-based curriculum, I propose a greater emphasis on 'narrative competence', among nursing students, lecturers and mentors (Corbally & Grant, 2016). This would involve a conscious focus on developing the skills of eliciting, attending to, interpreting and responding to the stories in our personal and professional lives. There is an assumption that these skills are acquired through interpersonal communication training and experience without explicit consideration of the nuanced skills of working with the stories people tell of their experiences. Just as I have gained new and richly detailed insights from the research participants, so nursing students can develop their practice competence by their improved abilities to engage with the stories their patients tell them, and educators through the stories their students tell them.

Reflections on the narrative analysis of the storied data

Detailed and multi-layered analysis of beginning nursing student stories reveals that they are a mechanism for ‘telling’ themselves into nursing; a portal for entry into new worlds. The novel world of clinical practice provides a greater number of ‘*tellable*’ stories than the more accustomed world of education, even higher education. In their stories, beginning nursing students make identity claims for themselves and their audience. These may be important opportunities to voice and perform how they view themselves. This may feel therapeutic and has the potential for learning. Telling a story provides an opportunity to re-perform an experience, accentuate aspects and come to understand it differently. Even those stories told about the observed practice of others provide an opportunity for the beginning nursing student to develop their own identity claim.

Individuals will employ a variety of story-telling forms or genres and achieve a variety of outcomes. Recounts enable the re-performance and appraisal of events while anecdotes allow the teller to access the emotion of the experience. Exempla provide an opportunity to express beliefs and values while narratively structured stories have the potential to illustrate the Figured Worlds inhabited by the student, how they resolve and make sense of experiences.

The Figured Worlds of the nursing student and the Student Nurse are not identical but do intersect. In this intersection the beginning nursing student has a space to author their emerging identity using stories as a symbolic device. These often provide a mechanism for buffering their proximity to the profession, associating themselves with the historical and cultural values of nursing whilst representing themselves as different and with a potential that makes them part of nursing’s future.

I believe, as do others in health related fields (Bennett et al., 2016), that Figured Worlds theory provides a currently underused framework for improving our understanding of identity development in unfamiliar professional settings. Emphasising the voice of the individual and the ways in which they author themselves as nurses, I feel Figured Worlds theory has the potential not only to explain but also to serve as a tool to help enhance ongoing identity development.

Insights on support for nursing student development

Evidence from the data suggests that the initial processes of becoming a nurse are challenging. Many of the issues raised in an earlier study by Melia (1987) appear to persist, further complicated by the need for beginning nursing students to engage across academic *and* clinical practice settings. In a parallel with beginning student teachers, the mismatch between the expectations and realities of practice prompt reconsideration and buffering. Recent research by ten Hoeve et al. (2017) has confirmed that while orientation and attitudes towards their new profession increase over the life of a pre-registration programme, there are considerable fluctuations, especially during the first year. Initial altruistic views about nursing are challenged by the realities of education and practice. This prompts individuals to adapt their own identities. While the quantitative work of ten Hoeve et al. (2017) and Cowin & Johnson (2015) sought to measure the phenomena, this thesis provides much needed narrative detail about how this occurs and how beginning nursing students respond. Through their stories it was possible to see that participants reinterpreted events, experiences and repositioned themselves and others. One common strategy was to conceive of themselves as part of the 'new generation' of nurses. This appeared to retain an association with the core values of caring, achieve an affiliation with the profession whilst retaining a differentiation given their status as new recruits and emphasise their potential.

Interestingly, lecturers and tutors were conspicuous by their absence from the stories told by all the participants and yet are recognised to be important models of professional values (Del Prato, 2013). If nurse educators in university settings have a stake in the development of professional identity amongst becoming nurses, a more explicit and tangible approach to developing professional confidence and competences may be appropriate. The status of the university tutor as a nurse may not be evident to students. Without the opportunity to 'be seen' to both *be and do*, students cannot utilise this resource (Secrest et al., 2003).

I believe that professional education must concern itself with supporting individuals to learn the 'doing of' nursing but not at the expense of their 'becoming as' nurses. Much of this latter development occurs covertly and sub-consciously, particularly as nurse preparation programmes are encouraged to include ever greater levels of content. Providing

opportunities for learners to share stories enables some of these implicit, hidden and unclear processes to become explicit, seen and clear (Atkinson, 1998, p7).

Methodological contributions

The relatively young discipline of narrative inquiry research poses particular challenges for novice researchers. While there is considerable methodological freedom, the lack of formal conventions has demanded that I create frameworks for myself, particularly in relation to the complexities of data analysis. In a recent review of relational research methods in health care [medical] education Clandinin et al., (2017) suggested the need to create '*narrative inquiry methodologies that allow the development of relationships over time*' (p94). I believe this thesis offers an illustration of a multi-dimensional, longitudinal and iterative approach to narrative analysis that begins to address this call.

There remains a professional tendency towards methodological and representational normativity dominated by traditional notions of evidence and causality (Grant, 2016). Narrative inquiry is gradually establishing its place in how we come to understand processes that are slow and evolving. It is enabling us to understand previously unseen or obscured aspects of the professional worlds we engage with. A recent World Health Organisation (WHO) report that recognises the legitimacy of narrative practices and research endeavours as evidence creates the potential for many more studies of this type (Greenhalgh, 2016). The health and education domains can only benefit from rigorous research employing longer term approaches that involve the capacity to capture individual experience and at the same time illuminate individuals' responses to new cultural contexts.

Further research

Developing from each of the four parts above are a number of potential areas for further research. Concerning the nature of the storied data, I feel the opportunity to gather and analyse stories from a more diverse group might yield significant additional insights. As the practice experiences of male nursing staff can be considerably different to their female counterparts (Whiteside & Butcher, 2015), so their stories may reveal additional perspectives and insights. Similarly, in a multi-ethnic and increasingly global society, the

influence of the student's ethnicity may prove a worthwhile line of inquiry and provide a way to privilege an additional set of voices.

Further longitudinal narrative inquiry research will require continued development of suitable methods, in particular, regarding the analysis of storied data. Alongside this is a need for improved understanding of the ethical relationships between researchers and participants in health care and education settings.

The focus for this thesis has been the transition into nursing, a critical and under examined aspect of professional identity development. Given the post-modernist orientation to the notion of identity as continually '*shifting, unstable and multiple*' (Rodgers & Scott, 2008, p733), there is considerable scope to explore identity development throughout a nurse's career. Health care and nursing practices in the 21st century are changing with political, economic and social drivers that previous generations of nurses have not had to address. Of particular interest to me would be to re-establish contact with these participants on completion of their programme in order to gather and analyse their re-told stories of 'becoming' from their future standpoint as registered nurses.

I would argue that encouraging/requiring students to *reflect* on past experiences, be they personal, academic or clinical creates restrictions and limitations on cognition that have the potential to discourage the very act itself. It requires that they become familiar with a set of analytical skills that are often difficult to master. By contrast, storytelling is an everyday, taken-for-granted ability that students rarely consciously regard as critical to their professional development but which afford considerable learning potential.

Vygotsky's (1986) understanding of learning, storytelling, or the creation of cultural artefacts, was that this enabled new participants in the field to establish an early sense of order and coherence that acted as mediators of future activity. Storytelling acts as a means of sense-making, learning and retention (Egan, 1989). As one matures in a setting, these mediations might lessen in prominence becoming internal tellings, somewhat 'fossilised' as a result of their limited external performance. As a person tells stories they establish connection between their experiences, interpretations, learning and the image of themselves to themselves and others.

Drawing on the ageless, communal and intergenerational nature of storytelling, narrative inquiry might be considered '*an ongoing process of thinking narratively*' encouraging the shift from thinking about stories to thinking *with* them (Huber et al, 2013, p226). Engaging in narrative inquiry enhances narrative competence, the skills of being able to take in, act on and be touched by the stories that surround us. It promotes the capacities of introspection and contemplation and an antidote to short-term 'problem-solving'. With these skills, researchers and practitioners in education and healthcare settings are better able to recognise and facilitate learning. They are also in a position to encourage and develop these skills in others.

A hugely exciting field for potential research exists in exploring how narratives are used as alternative ways of communicating professional knowledge. The stories of how professionals experience and therefore understand the events, relationships and interactions in their lives provide a rich seam for exploration. Increasing recognition of the validity of narrative approaches in higher education and across a range of disciplines makes these endeavours timely.

Final thoughts

Reflecting on a period of illness and his own memoir written in 1995, Frank (2013) articulates '*two recognitions of human life that sound paradoxical but are actually complementary.*' (pXIII) and which encapsulate the comfortable and necessary standpoint adopted in this study. The first is that people's experiences are unique and it is this uniqueness that affords these experiences significance in developing and understanding the self. Experiences are intimately personal even when occurrences are familiar to many others. No-one else has or will ever experience the same set of circumstances that become part of the unique mix of personhood. While others, including researchers, may recognise shadows and images of others' lives, it may only be to that individual that the significance of the weave is truly known. The second is that experiences can only be embodied and understood in the context of a shared culture that provides words, images, and artefacts for their capture and communication. Without these, we are unable to express to others or to

ourselves the implications of happenings themselves and the resultant contribution to our unique biography.

Appendix 1: Glossary

Adult Nursing – one of 4 branches of nursing (the others being Children's, Mental Health and Learning Disability).

Auxiliary – see Health Care Assistant

BNF (British National Formulary) – A pharmaceutical publication.

Cannula – A small plastic tube inserted into a vein for the administration of drugs and fluids.

Clinical Skills session – Skills sessions conducted in a simulated clinical environment within the university.

Care Quality Commission (CQC) – The independent regulator of all health and social care services in England.

Dysphagia – difficulty swallowing.

Health Care Assistant (HCA) - a non-registered member of the nursing workforce.

General Nursing Council (GNC) – forerunner to the UKCC, the professional regulatory body.

Mentor – a registered nurse who has completed a post-registration module covering the facilitation and assessment of practice learning.

Nursing and Midwifery Council (NMC) – the professional regulatory body for registered nurses and midwives in the UK.

OSCE (Objective Structured Clinical Examination) – a form of timed assessment, often carried out in a simulated clinical environment.

Person-centre care – An approach to care that puts the person, rather than a patient, at the centre of care.

Pre-registration – the period of time before a nurse has completed the NMC requirements for registration as a professional nurse.

Pre-service – as Pre-registration.

Registered Nurse – a person who has successfully completed an NMC validated education programme and is entered on the professional register.

Simulated practice – See Clinical Skills session.

Support Worker – a non-registered member of a social care team.

Suprapubic catheter – a urine drainage tube inserted through a hole made in the abdomen above the pubic bone.

United Kingdom Central Council (UKCC) – the forerunner to the NMC, the professional regulatory body.

Venepuncture – the insertion of a small plastic catheter into a vein for the purpose of blood sampling, medicines administration or fluid replacement.

Appendix 2: Key events and regulatory developments in UK pre-registration nurse education

<i>Year</i>	<i>Key events and regulatory developments</i>
1860	Florence Nightingale establishes the first nurse training school at St. Thomas's Hospital, London using an apprenticeship model.
1919	<i>The Nurses Registration Act</i> . This led to the establishment of the General Nursing Council (GNC) in 1920. The GNC was required to maintain a register of those who had completed recognised general and specialist training provided by independent hospitals.
1943	<i>The Nurses Act</i> . This was the first statutory recognition of the State Enrolled Assistant Nurse (SEAN). It created two statutory levels. Registration required 3-year preparation and Enrolment 2 years.
1948	Foundation of the National Health Service providing comprehensive health care, free at the point of delivery.
1960	The first bachelor's degree in nursing is launched (University of Edinburgh). The majority of nurse education was still provided by Schools of Nursing attached to hospitals.
1964	Platt Report recommends students should be independent from hospitals and receive grants from the Local Education Authority (RCN Special Committee on Nurse Education).
1972	The Briggs Committee recommends an increase in pre-registration degree preparation (provided by universities) and that nursing become a research-based profession.
1983	The United Kingdom Central Council (UKCC) was established, replacing the GNC, with responsibility for monitoring education standards and maintaining the nursing register.
1985	The RCN Commission on Nursing Education recommends (in the Judge Report) the transfer of nurse education to higher education. They also advocate that students should be supernumerary and not part of a practice environments complement of staff.

Continued

1986	The UKCC launches <i>Project 2000</i> which formalised the move of nurse education to higher education, established diploma level study as the minimum exit award and an 18-month Common Foundation Programme (CFP) followed by 18-months of specialist (branch) education in Adult, Children's, Mental Health or Learning Disability nursing. This marked the end of Enrolled Nurse preparation.
1997	<i>The Nurses, Midwives and Health Visitors Act</i> . This required the UKCC to formalise the content of pre-registration nurse education.
1999	The UKCC Commission for Education evaluation of Project 2000 recommends a one-year CFP and two-year branch programme.
2001	UKCC publishes <i>Fitness for Practice and Purpose</i> establishing a minimum for pre-registration course of 4600 hours equally split across theory and practice endeavours.
2002	The UKCC and National Boards are replaced by The Nursing and Midwifery Council (NMC) which currently has the Quality Assurance role for nurse education.
2004	The NMC publishes Standards of proficiency for pre-registration nursing education, drawing together Statutory instruments and Council policy into a single document.
2005	Article 31 of European Union Directive 2005/36/EC sets standards for pre-registration nurse education in line with the UK requirements for 2300 hours of theory and 2300 hours of practice.
2008	The NMC declared that the minimum academic level for pre-registration nurse education should be bachelor's degree, a decision endorsed by UK ministers in 2009.
2010	The NMC publishes <i>Standards for pre-registration nursing education</i> which include sections covering competence and the standards by which Approved education institutions (AEIs) are evaluated.
2013	All UK pre-registration nurse education moved to degree or post-graduate (Master's) level.

Appendix 3: Audio diary guide and instructions

Charging the USB digital voice recorder

The device is pre-charged and will record for approximately 12 hours. Each time it is inserted into a USB port, it will fully recharge in 1-2 hours.

Recording an audio diary entry

The USB digital voice recorder is designed to be very simple to use. There is no software to install in order to operate this device. It can be used while inserted into a USB port but is most convenient and portable when used hand-held.

1. Near the top of the device is a slide switch. Moving this from 'Stop' to 'Rec' illuminates a red light. Once this goes out (about 2 seconds), you can begin to record your entry. The microphone will pick up normal speech between 50 and 100cms
2. When you have finished, slide the switch to 'Stop'.
3. If you wish to record more, simply repeat the process. Each time the recorder is stopped it saves the audio to a new file automatically.



Using the device as a USB memory stick

You can use the device to store other documents. A 'My documents' folder has been set up for you. As with any device of this type, you are encouraged to make back-up copies of any important documents you create. Please ensure your assignments are saved elsewhere if you are using the device for this purpose.

You may keep this device at the end of the research project or if you chose to withdraw, which you are free to do at any point. You will *not* need to return it.

Appendix 4: University Research Ethics Committee approval letter



Professor Debra McGregor
Director of Studies
School of Education
Faculty of Humanities and Social Sciences
Oxford Brookes University
Harcourt Hill Campus

11 August 2014

Dear Professor McGregor

UREC Registration No: 140833

'Figuring and becoming': first steps on the road to forming personal, professional and academic identities among beginning student nurses

Thank you for the email of 26 July 2014 outlining the response to the points raised in my previous letter about the PhD study of your research student Dan Butcher, and attaching the revised documents. I am pleased to inform you that, on this basis, I have given Chair's Approval for the study to begin.

The UREC approval period for this study is two years from the date of this letter, so 11 August 2016. If you need the approval to be extended please do contact me nearer the time of expiry.

Should the recruitment, methodology or data storage change from your original plans, or should any study participants experience adverse physical, psychological, social, legal or economic effects from the research, please inform me with full details as soon as possible.

Yours sincerely

A handwritten signature in black ink, appearing to read "Hazel Abbott".

Hazel Abbott
Chair of the University Research Ethics Committee

cc Dan Butcher, Research Student
Maggie Wilson, Research Ethics Officer
Jill Organ, Research Degrees Team
Louise Wood, UREC Administrator

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Appendix 5: Transcription convention

<i>Characters</i>	<i>Meaning</i>	<i>Example</i>
()	Interruption overlap in the clause	N: I wasn't sure what to say (R: OK) and I found it rather difficult.
[]	Explanation / non-verbal / laugh etc	When I was at the New Southern [pseudonym for hospital] it was very relaxed [laughs].
=	Interruption /turn	N: The machine wasn't working. It was= R: = broken?
<u>Underlined</u>	emphasis by narrator	<u>That's</u> really interesting
.h or.hh	Audible breath	Well you see .hh the aim of the game was not clear
(?)	Inaudible or unsure	He said he was (? tired) but able to work
-	Cut off in speech	They never know when to sto- (...) It can be frustrating sometimes!
Umhum, Um, Err	Non-lexical expressions	I was never sure that I (..) um (..) never sure that I wanted to come to University
(...)	pause (up to 3 seconds)	It was (..) difficult
(time)	longer pause	It was (6 sec.) difficult
::	extend previous vowel	So soo::n [ie - so soooooon!]

Based upon Anglian Ruskin University (<http://web.anglia.ac.uk/narratives/transcons.phtml>) [Accessed 30th October 2016]

Some points are drawn from Watson C (2007) Small stories, positioning analysis, and the doing of professional identities in learning to teach. *Narrative Inquiry*. 17(2), 371-389 and Powers, WR (2005) *Transcription techniques for the spoken word*. Lanham: Altamira Press.

Appendix 6: Examples from Data Analysis Frame

Structural Analysis

Anecdotes – Yellow, Narrative – Blue, Recount – Red, Exemplum – Green

Andrea

Story	Title/name	Content	Commentary	Relational Analysis	FW, Emotions and other ideas
A8	'I hadn't experienced that before'	Andrea tells of how she felt on hearing about her first allocation of clinical placements. The initial disappointment was replaced by acceptance and excitement following uniform fitting. A visit to the ward caused some concern when Andrea heard a person with dementia calling out, something she had not experienced before. Prior to leaving she had the chance to see this person, who seemed fine and so she was reassured.	There is a great deal of reference to feelings in this brief anecdote. Andrea is disappointed, glad, excited, scared, distressed, fearful and proud. The timespan is not explicitly stated but appears to be less than 2 weeks with all these emotions in operation. Andrea's disappointment at the placement allocation appears to be that it was not distinct from her previous experience. She responded to this by reappraising the situation, focusing on the role as different. She also undertook a visit as had a new experience which she associated with her new role of nursing student. The distressing aspect of the visit was seeing (or rather hearing) the distress of others. Andrea had to be reassured that the person was not in distress and used her own assessment (based on a brief visual one-way contact) to achieve this. There was no more concrete evidence of this but it served to help manage some of the emotions.	Andrea is positioning herself as a legitimate nursing student in this anecdote. She recalls a range of emotions including excitement, upset and fear but not to a level that she deems unreasonable. Having completed skills sessions at the University she concludes 'so we're prepared in that way.' The uniform appears to assist with the sense of legitimacy (We had our uniform which was really exciting and I feel, I don't know, it's kind of real. [Laughs] Well it is real.' Having worked previously for 7 years in HC settings, the novel experience of someone with dementia making a noise was contrasted across the story with the initial disappointment of the placement allocation. The new experience appears to legitimise the new role of student nurse.	The primary function of this anecdote is the expression of the range of emotions that seem to represent a feeling of 'real'. The tour of the ward, the induction, new uniforms and the positive reaction of the staff all played a part.

Beth

Story	Title/name	Content	Commentary	Relational Analysis	Emotional Analysis FW's and other ideas
1B4	<i>'Oh my gosh. Other people think and feel like me.'</i>	Beth talks about the insights she developed while at University. She sets the scene by indicating that she did not want to go to University (the first time) just for the sake of it. She went travelling and returned with some personal ideologies that she did not feel people knew or understood. Her Anthropology degree brought her into contact with others who had similar views and the realisation that she was not the only one thinking like this. She used this to move from a general state where she enjoyed learning to one where she felt it provided a foundation or platform for her world-view.	<p>This story is quite short but has the structural elements of a narrative. It is linked to 1B2. There is a crisis (personal) and although the influencing actors are not named or spoken of, the power of the culture is clearly the force driving change. The resolution is about how Beth sees herself as a person and as a learner.</p> <p>This narrative has quite an emotional charge to it and included emphasised sections and reports of thoughts. This may be a very important story in terms of how Beth sees herself and may inform other stories or form a narrative thread.</p>	<p>Beth presents herself as a traveller in both a literal and metaphorical sense, committed to the journey of learning rather than the achievement of a particular outcome. It is her bildung to this point '<i>I just love learning. I thrive on learning</i>' are clear identity claims (Philomathic) – '<i>this is what I'm about.</i>' She refers to a feminist '<i>platform</i>' and '<i>routes</i>' to understanding. There are unnamed others from her previous study period who are positioned to validate her own thinking. The result was '<i>empowerment</i>' and growth through validation which contributes to Beth's personal view of the FW of education.</p>	<p>In Beth's FW of education, there are people that she can associate with who '<i>feel and think like me</i>'. The expressed emotions in the story include anger (related to feminism, feeling accepted (respected, valued)) and a degree of contentment or happiness with who she is.</p> <p>The traveller or journeymen idea is part of Dahlgren's work</p> <p>Communion</p>

Denise

Story	Title/name	Content	Commentary	Relational Analysis	Emotional Analysis FW's and other ideas
D9	<i>'It was an eye-opener and I understand now what it's like to work with people with head injuries.'</i>	<p>Denise recalls one of her first clinical experiences as a nursing student. She is asked to monitor/supervise a person who had undergone surgery two weeks before following a head injury.</p> <p>Denise recounts how she spent time conversing with him and occasionally accompanying or following him as he left his hospital room.</p> <p>Her objectives as she understood it was to help keep this person calm but she did not feel prepared. Much of the account is about her emotions regarding the situation and she briefly mentions the impact on this person's family.</p>	<p>Dominated by a range of expressed emotions, this recount is the story of realisation and a sense of being 'powerless'. Denise, who has had previous care experience, is placed in a situation where she feels uncomfortable because of lack of experience and knowledge. They appear to represent the non-nurse in a clinical situation where Denise feels out of control but also unsafe and therefore vulnerable..</p> <p>The tone of the story is mixed. There is a degree of annoyance at having been put in a situation which she felt required someone with knowledge and skills that she does not have. In contrast, she is also expressing satisfaction with herself that she was able to achieve what she felt was the objective, namely to 'keep him calm'.</p>	<p>Denise presents herself as being unprepared for the situation she faced and the patient as a little threatening.</p> <p>There is no resolution (<i>'That's just an experience I wanted to share um on one of my placements.'</i>) The story is driven by the emotional energy of fear initially but also a desire to perform a revelation and realisation about the nature of nursing work, the learning that is required and vulnerability in certain clinical situations.</p> <p>The message in the story was 'I was thrown in at the deep end' and not adequately prepared, but that I coped. This is similar to the findings of Draper et al (2010) when they considered the experiences of newly registered staff. This story does not offer a resolution but is an example of resilience (?) in the face of adversity. This is similar to the notion of transition shock that is reported by Duchscher (2009) and experienced by those moving from student to registered nurse roles.</p>	<p>Denise introduces this story in the context of feeling anxious, fearful and overwhelmed but towards the end there is a sense of satisfaction (self-satisfaction) (<i>'I mean I did handle the situation quite well'</i>). This seems to be an 'I've been there story'. It may well have been told to family members and other students as a means of showing credibility and may well be told again in the future to illustrate <i>'We've all been there'</i></p>

Helen

Story	Title/name	Content	Commentary	Relational Analysis	Emotional Analysis FW's and other ideas
3H14	<i>I really want to meet those situations and not think 'I don't know what the hell I'm doing.'</i>	<p>This is a repeated tale of Helen's previous job and how she felt about it. She Includes the reported conversation with her Husband as a means of contextualising this.</p> <p>Helen talks about a previous 'constant state of anxiety' that's he felt when working as a Housing Officer and contrasts this with how she felt about restarting a clinical placement.</p> <p>Helen goes on to recall a recent incident working as a Foot Health Practitioner and her desire to have knowledge and skills. She parred back some skin on a person's foot which then began to ooze and she was concerned this may be a problem she had caused. The GP confirmed it was nothing of concern but it highlighted to Helen her own competence but also her satisfaction with the pathway that she is following.</p>	<p>This narrative includes a crisis in more than one form. There is the issue of how Helen responded to returning to work in the past and now. She also tells a story from her Foot Health practice to illustrate what it is she is trying to achieve by completing the programme.</p> <p>The resolution is the contentment with the pathway she has chosen. Helen sees herself as incompetent but this does not appear to concern her. She has a sense of what she would like to feel in the future and be able to deal with but reports that she does not have a mental image. She is still 'imaging'.</p>	<p>The revelation in this story (for me but probably not for Helen who already knew this) seems to be that the end result of the nursing programme is not 'to be a nurse' but to have 'experienced becoming a nurse'. It seems to be more about the journey than the destination. <i>ce que tu fais te fait</i> – it is through his acts that man is built</p> <p>'So seeing myself as a nurse, I don't know, I don't, I just really want to do it.'</p> <p>This is exploratory narrative processing in order to clarify and rehearse what it is that Helen wishes to gain from her engagement with a pre-registration nursing programme. She is seeking confidence in dealing with situations in the belief that this is what she will gain. By explicitly stating what she does not want to be (<i>'I don't want to be a matron, I don't want to be, you know, a nurse-practitioner.'</i>) Helen is setting a limit on her achievement and initially ruling out management. The emphasis is placed on clinical abilities</p>	<p>This story contrast sharply with Julia who needs an image needs to be able to see herself as a nurse. Perhaps this is a feature of age and experience. Helen has other ways to see herself while Julia may be significantly more restricted in this.</p> <p>The FW of practice for Helen involves staff who are able to manage situations with confidence. Because she cannot imagine herself doing this, her FW is not likely to be as clear as some others, possibly because it is not as simple. (<i>'A figured world is a picture of a simplified world that captures what is taken to be typical or normal'</i>, Gee, 2014, p176)</p> <p>Helen is trying to simplify this world by eliminating a future that has managers and specialist?</p>

Julia

Story	Title/name	Content	Commentary	Relational Analysis	Emotional Analysis FW's and other ideas
113	<i>'She will look at the one she wants'</i>	<p>This story is a retelling of a practice experience. Julia had worked with many people who have communication impairments and identified that one particular person was not only able to make decisions but was able to communicate these through her gaze.</p> <p>The focus of this short story is that, despite telling other that this is the case, they do not believe Julia and, as a result, this person is not treated as an individual.</p>	<p>While there are a series of linked events and the sense of an outcome, this exemplum is used as an opportunity to (as with previous stories) illustrate or narrate some of the values that Julia believes are important for nurses.</p> <p>She begins the response with the explicit statement <i>'I think I'd be a good nurse.'</i></p> <p>The outcome, as illustrated by the pauses punctuating the account would suggest this was not a clear-cut resolution as in the previous story.</p>	<p>As with some of the other stories, Julia is presenting an alignment with residents and willing to challenge the actions of other staff (<i>'and I've seen a lot.'</i>). This might replicate what Furlong & Maynard (1995) identified about student teachers. Julia is performing ambition and drive through her statements of becoming a nurse manager and her portrayal of what she thinks this involves based on the role-model of her Aunt. She is presented as the embodiment of valued characteristics (<i>'she'd tell them there and then', 'It wasn't belittling, it was firm.'</i>). These help in creating an image of her future self as a leader (<i>'And I think I'd make a pretty good leader.'</i>) The identity claim is that 'I have the potential' based on the experience and insight so far.</p> <p>She sees herself as someone capable of changing clinical situations and that they need changing.</p>	<p>The emotions associated with the resident story are not clear.</p> <p>In the second section Julia there is evidence of an energetic emotion conveyed in the way the story is told.</p> <p>There is a sense that the role-model Julia refers to is no longer the same person as they used to be and that this may be a feature of the current culture. <i>'it was kind of like actually how a Matron should be', 'when she was at her prime'. 'I don't want to be pushed out of it. I want to stand my ground.'</i></p> <p>Julia sees herself as the next/new generation. (Beth and Denise talk about generational shifts)</p> <p>The FW of clinical practice needs changing. This is the conclusion and view Julia expresses. There appears to be no sense of the history or progress achieved to date.</p>

Appendix 7: Wheel of Emotions

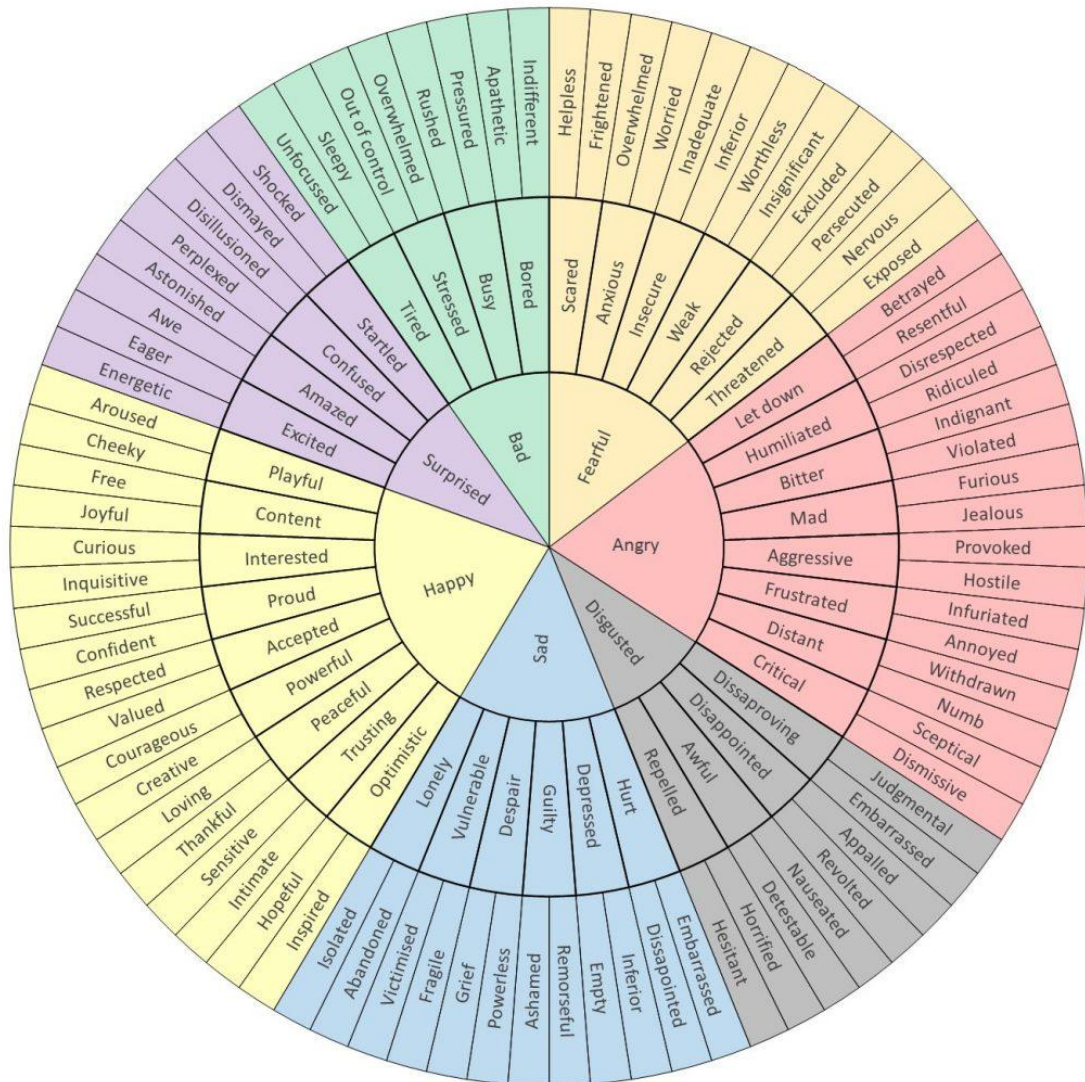


Image from <http://www.christinejayne.co.uk/blog/?p=1> [Accessed 3rd Nov 2016]

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