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Nursing - A Work of Heart

An analysis of pediatric nurses' perceptions of their working situation.

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Abstract

Title: Nursing - A Work of Heart: An analysis of pediatric nurses' perceptions of their working situation.

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Research Question: How do pediatric nurses perceive and cope with their working situation?

Purpose: The research study aims to create a deeper understanding of how pediatric nurses perceive their working situation and how it affects them. Furthermore, we intend to give insight to what the role as a pediatric nurse really entails, apart from the work tasks. Hence, the study aims to contribute empirically, but also theoretically to the concept of identity by investigating pediatric nurses' personal experiences.

Methodology: The ontological approach of the study is social constructionist, an interpretative epistemology, and an abductive research approach. To answer the research question and fulfill the purpose, a qualitative research study has been done with semi-structured interviews with eight pediatric nurses and assistant nurses.

Theoretical Perspective: The literature review presents previous research regarding professionalism and professional work, followed by research on emotional labor, both in the context of nurses. Thereafter, the concepts of identity and identity work are introduced.

Empirical Foundation: The empirical findings regarding the pediatric nurses' experiences of their working situation is presented. This is followed by an analysis of how the nurses' experiences can be interpreted as if the working situation is undermining the ability to maintain a coherent role. The identity work of pediatric nurses is further theorized into five new terms.

Conclusion: The interviewed pediatric nurses are experiencing a paradox, where they experience multiple emotional threats to their identity as a nurse due to the working situation, yet the working situation is also what helps them maintain their self-esteem and certainty, and thus their identity.

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Happy reading!

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1 Introduction

This research study aims to investigate how pediatric nurses perceive and cope with their working situation. In the following chapter a background of the subject will be presented by emphasizing the stressful working environment of nurses through statistics. This is followed by a problematization, where current research is presented shortly in order to highlight the identified research gap that we aim to contribute to. Finally, the purpose of the study is declared, followed by the research question that will guide the research.

1.1 Background

The importance of mental wellbeing and its links to employee wellbeing, as well as benefits to organizations has been the central focus of multiple academical research (Ipsen, Karanika-Murray & Nardelli, 2020; Bagheri et al, 2019). Organizational performance and mental health are considered to be naturally connected in the sense that organizational performance depends on how effectively the organization functions and therefore how effectively its people function (Neely, 2005; Peccei & Van de Voorde, 2016). Possible risks within workplaces include a high workload, inflexible work hours, unclear tasks, low levels of support etc. (Arbetsmiljöverket, 2020; Montano et al., 2016; WHO, 2022). Furthermore, mental wellbeing issues as described above have become the most common reason for sick leave in Sweden (Folkhälsomyndigheten, 2021). Across industries in Sweden, the healthcare industry has the highest rate of sick leave due to psychological reasons (Försäkringskassan, 2016; Lidwall & Abrahamsson, 2022). The Swedish *Arbetsmiljörapporten* (eng: Working Environment Report) released results showing that amongst 8500 survey participants within the healthcare industry, 81% felt the need for longer recovery between shifts and 50% are considering applying for other jobs due to stress (Hjorth, 2022). This problem is further recognized by scholars worldwide, Smith et al. (2021) argue that the depletion of nurses' wellbeing has been a perpetual problem for a long period of time, due to the components of their job. Furthermore, the field of pediatric nursing is considered to involve an even heavier emotional burden, since emotional management becomes more difficult when caring for children along with the additional burden of having to care for their patients' families as well (Erikson & Davies, 2017).

The nursing role has recently been discussed to a greater extent, and it has been implied that they experience a great deal of contradicting expectations (Ashforth & Humphrey, 1993). This results in nurses having to navigate between these contradicting external and internal expectations regarding how they ought to feel, act and be as nurses. Nurses are expected to feel empathetic and supportive (Ashforth & Humphrey, 1993) but are at the same time expected to manage their emotions and the professional expectations involved in their professional role (Bolton, 2000). These contradictions imply that there are multiple expectations affecting nurses' perceptions of themselves. Ashforth and Johnson (2001) further mention how professionals are often forced to navigate between multiple identification demands. Alvesson (2004) further argues that jobs that lack clear material grounding have high levels of ambiguity related to what knowledge is needed, what the work entails and what performance is acceptable, which complicates their working situation. Therefore, we found this field of research interesting and identified a need to investigate how pediatric nurses experience the implications involved in their work, as discussed above.

1.2 Problematization

Over the years, vast research has been presented discussing professionalism, and therefore there is no set definition of the term. However, researchers often agree on the fact that professionalism means belonging to a group of professionals with high level of specialized and theoretical knowledge (Andersen, & Pedersen, 2012), and that professionals often identify with their profession (Freidson, 2001; De Braganca & Nirmala, 2017; Schmidt & McArthur, 2018) . Professionalism is said to have positive effects on individuals due to the autonomy provided (Hofstede, 1981), but we recognize that people might react differently to the autonomy as it creates a greater pressure and expectations on professional workers. Nursing was for a long time considered as a semi-professional profession (Adams & Miller, 2001), which has changed in previous years, in line with the development of education and professional certificates. Nursing is thus now considered as a professional profession (Ghadirian, Salsali & Cheragi, 2014). Accordingly, professionalism has been investigated thoroughly within the profession of nursing, as the emotional aspects of the work sets nursing apart from other professional jobs (Lynch, Surdyk & Eiser, 2004). Although nurses go through a solid education preparing them for their professional job, the practice of being a nurse is different from the theory taught in the education due to the emotional aspects (Maguire & Price, 2007; Buder & Fringer, 2016). However, they are rarely

taught how to respect the professional boundaries that arise in the workplace, and we therefore see a need to investigate how nurses themselves experience and navigate within these boundaries in their work.

Miller (2002) argues that emotions are an integral part of the workplace, and there is thus a need for emotion management in every workplace (Thompson, 1994). Working within healthcare is no exception, especially not for nurses due to their close contact with the patients. Nurses therefore need to work with emotional labor, which is defined as the act of displaying the suitable emotions in the right situations (Hochschild, 1983), and thereby follow the display rules of being a nurse (Ashforth & Humphrey, 1993). Furthermore, society expects nurses to be compassionate, empathetic, and supportive towards the patients and their families (Cain, 2012; Mann, 2004; Ashforth & Humphrey, 1993). At the same time, they are expected to live up to societal expectations regarding their role as a nurse, like clinical tasks and decision making (Bolton, 2000). This balancing act of professionalism and emotions can thus cause nurses distress (Bolton & Boyd, 2003), especially within pediatrics (Erikson & Davies, 2017). The emotional aspects of nursing work seem to impact the levels of professionalism, but limited research exists regarding professionalism within the field of pediatrics which is why we see the need to investigate it further, on an individual level.

Balancing differing expectations as a pediatric nurse can be threatening to their self-concept, and thereby their identity. Identity is a concept constructed through interactions with others. It is personal and is what makes one person perceive a situation differently from someone else (Billing, 2006). A person could have several identities at the same time, and a nurse could thus be both a professional nurse and an emotional private person (Alvesson & Billing, 2011). However, the creation of identity is continuous, meaning that an active effort is required to create and maintain the identity, which is known as identity work (Alvesson & Willmott, 2002; Sveningsson & Alvesson, 2003). Identity work is thus triggered in situations where the personal identity is being questioned, or when input from the social environment is threatening the self-concept (Alvesson & Sveningsson, 2016; Eilam & Shamir, 2005), which due to the balancing of professionalism and emotions, is relevant for pediatric nurses. Sveningsson and Alvesson (2016) present five different types of identity work for managers; identity adjustment, identity expression, identity juggling,

identity wrestling, and identity crash, where the personal identity is differing more and more from society's image of the identity. Sveningsson and Larsson (2006) present hopes for the future as another form of identity work. These types of identity work are however only presented in relation to managerial work, and we would therefore like to investigate further how these terms could be elaborated upon to suit pediatric nurses.

Based on this previous research, we have identified a correlation between the troublesome navigation of professionalism and emotions within pediatric care and identity work, which we would like to investigate further. There is thus a research gap, in how pediatric nurses themselves perceive their working situation and how it affects their identity.

1.3 Purpose and Research Question

The research study aims to create a deeper understanding of how pediatric nurses perceive their working situation and how it affects them. Furthermore, we intend to give insight to what the role as a pediatric nurse really entails, apart from the work tasks. Hence, the study aims to contribute empirically, but also theoretically to the concept of *identity* by investigating pediatric nurses' personal experiences.

To fulfill this purpose the following research question has been formulated:

How do pediatric nurses perceive and cope with their working situation?

2 Literature Review

In this chapter we discuss and provide an overview of theoretical concepts connected to various aspects of working within pediatric care. First, we present literature on professionalism and emotional work, and how it correlates to being a nurse. This is followed by a presentation of identity and identity work. The Literature Review will thus be structured as seen in Figure 1.

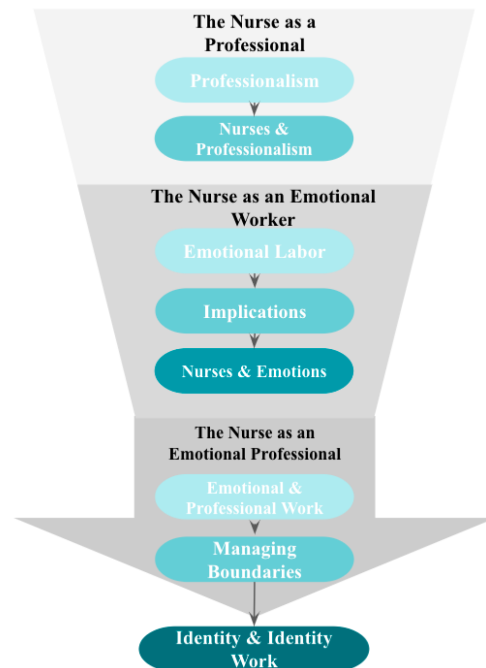

Figure 1: Overview of Literature Review

2.1 The Nurse as a Professional

2.1.1 Professionalism

In order to research the working environment of pediatric nurses, it is of great importance to understand and define the different internal and external expectations and struggles present. Therefore, we argue that it is relevant to review literature on what being professional entails since we aim to examine how the expectations of them being professional affects them, emphasizing the professional knowledge involved in their work. Apker, Ford, and Fox (2003) argue that a great deal of individuals identify specifically with their profession, which leads to them defining themselves according to their profession (Pratt, Rockman & Kaufmann, 2006). As opposed to identifying with one's organization, Vough (2012) argues that professional identification most often remains relatively stable throughout one’s career. The term professional identification is defined as “professional employees’ sense of oneness with their profession” (Heckman et al., 2009, p. 510). This identification with one's profession leads to professionalism due to the commitment to their particular profession (Wynd, 2003).

Professionalism can be defined as professionals belonging to professions that involve high levels of specialized and theoretical knowledge along with strong intra-occupational norms (Andersen & Pedersen, 2012). A general consensus among scholars is that *professionalism* involves the representation of attitudes relating to identification with and commitment to a particular profession (Freidson, 2001; De Braganca & Nirmala, 2017; Schmidt & McArthur, 2018). Fitzgerald (2020) argues that *professionalism* is demonstrated in the interactions, responsibilities, and attitudes expected of *professionals* when interacting with not only individual clients but also society as a whole. Due to these external expectations and influences on *professionals*, *professionalism* can be described as a multidimensional construct which involves intrapersonal, interpersonal, and public features (De Braganca & Nirmala, 2017; Schmidt & McArthur, 2018). However, the term *professionalism* does not seem to have a single fixed meaning which is further supported by Fitzgerald (2020) who states that the term is often used without a clear definition or even conflicting definitions. Therefore, we will also define and make use of the terms *professional work* and *professionals.* According to Abbott (1991) *professional work* refers to applying abstract professional knowledge to specific client problems. Andersen and Pedersen (2012) elaborate on how the educational and professional standards and norms lead to higher levels of specialized and theoretical knowledge. Ghadirian, Salsali and Cheraghi (2014) further describe how *professionals* are developed through a process of socialization, beginning with formal education to acquire initial knowledge and skills. This suggests that acquiring knowledge through formal education is not enough and therefore professionals such as pediatric nurses, are constantly developing their professional knowledge.

We therefore argue that it is of great importance to review literature regarding how *professional work* affects *professionals* and its possible negative outcomes. This is important since the aim of the study is to detect and analyze the influential factors on pediatric nurses' perception of their working environment. Freidson (2001) suggested that *professionalism* is in fact a system of practices which are founded in core values allowing skilled professionals to make professional decisions individually, without having to ask their superiors for permission. This value-infused identity, without the interference of superiors, can also be defined as *occupational professionalism,* a pure kind of *professionalism* derived from the inside of the profession (Evetts, 2013). Freidson

(2001) emphasized how *professional work* is characterized by the exercise of collegial control within the profession. This can be contrasted with bureaucratic control where control resides in an administrative hierarchy or market control where clients ultimately decide. This autonomy provided to *professionals* evidently leads to increased accountability (Hoyle & Wallace, 2005). Moreover, *professionalism* depends on established jurisdictions within which professionals maintain monopoly in performing tasks. Professional workers therefore often have close to complete autonomy, since the complexity of specific individual cases make it difficult to establish procedural control or post result evaluation (Hofstede, 1981). Abbott (1998) and Jamous and Peloille (1970) however argue that professionals working in the frontline depend on both autonomy and standardization. They rely upon standardization in order to make their professional procedures and outcomes consistent and comparable (Abbott, 1988; Timmermans & Berg, 2003). Thus, highly skilled professionals are expected to fulfill the professional side of their role, by acting autonomously and being able to make professional decisions without having to turn to superiors first. This can be seen as a positive aspect of *professionalism*, nevertheless this also causes greater pressure and expectations to professional workers which we identify as important to investigate further. Hall (1968) researched which attributes correlated positively with *professionalism* and found a sense of calling to the profession in question to be a strong indicator. Furthermore, his findings suggested that nurses scored especially high in regards to experiencing a sense of calling, and thus scoring high in *professionalism.* He attributed this strong sense of calling partly to the common commitment to the profession despite the low wages. Therefore, we argue that it is important to review literature regarding *professionalism* within the context of the nursing profession.

2.1.2 Nurses and Professionalism

For many years, the nursing profession was considered to be a semi-professional field of work (Adams & Miller, 2001). Over time, developments of educational standards and professional certificates within the nursing profession has led to their work gaining professional status (Ghadirian, Salsali & Cheragi, 2014). Due to the professionalization of nursing, the increased accountability consequently increases the pressures on pediatric nurses since the stakes become higher and the consequences rely upon their professional decision (Hoyle & Wallace, 2005). In order to examine how the professional nature of nursing work affects their role as professional

nurses, we reviewed existing literature and research on how the *professionalism* of nursing work plays out. The term *professionalism* has been defined and discussed to a great degree, especially in regards to medicine and nursing work (Azemian, Ebadi & Afshar, 2021; Ghadirian, Salsali & Cheraghi, 2014; Lynch, Surdyk & Eiser, 2004). Lynch, Surdyk and Eiser (2004) define *professionalism* in the context of medicine as: "the ability to meet the relationship-centered expectations required to practice medicine competently" (p. 366). In recent years it has become more common for child patients to have their families around during the majority of their hospitalization. Due to this increase in relationship building between pediatricians and their clients' families, Fallat and Glover (2007) further argue that it has become more important than ever to adopt a standard of *professionalism* for pediatricians. Pediatric nurses are thus expected to withhold *professionalism* in the sense that they are expected to make rational decisions, apply analytical thinking, and follow standardized procedures. Their education further provides them with not only the tools but also expectations regarding how *professional* their work ought to be.

2.2 The Nurse as an Emotional Worker

2.2.1 Emotional Labor

Having discussed the essence of *professional work* and *professionalism,* which relates to the work of pediatric nurses to a great extent, it is also important to discuss and define other influential factors of their work, such as the *emotional labor* involved. Vast literature exists discussing the roles of which emotions play in organizational settings (James, 1989; Rafaeli & Sutton, 1987, 1989, 1991; Stenross & Kleinman, 1989). Miller (2002) goes as far as stating that "emotion is an integral part of the workplace" (p.588). Societal, professional, and organizational norms decide which emotions are appropriate in certain settings which results in the need for carefully managing naturally emerging emotions, such as expressing anger towards clients (Hochschild 1983; Tracy, 2005). This results in the need for *emotion management,* which is an essential skill for a great number of employees. Thompson (1994) describes *emotion management* as: "the unwritten task of managing one's emotions – the extrinsic and intrinsic processes involved in monitoring, evaluating, and modifying emotions to accomplish goals" (pp. 27-28).

The connection between emotions within professional roles taking place within organizational settings is often referred to as *emotional labor.* The widespread and acknowledged theory of

emotional labor was presented by Hochschild (1983) who defines emotional labor in the context of service work as: "the management of feeling to create a publicly observable facial and bodily display" (p.7). The term *emotional labor* thus differentiates from *emotional work* since it focuses on how individuals manage their emotions publicly and professionally, while *emotional work* refers to private emotion management in relation to personal relationships such as with friends and family (Hughes, 2010). The theory thus describes the often invisible work required of service workers when interacting with their clients, which is exchanged for a payment and consequently, has commercial value. Hochschild (1983) further argues that *emotional labor* requires induction or even suppression of personal feelings in order to make clients or patients feel safe. Each emotional laborer is expected to adhere to *feeling rules* (Hochchild, 1983) and *display rules* (Ekman, 1973). *Feeling rules* refer to rules which service providers are expected to feel in certain situations (Hochchild, 1983). *Display rules* however, refer to how service providers are expected to behave and display those emotions expected, using verbal and nonverbal communication (Ekman, 1973). Thus, combined they refer to the emotions that society expects service providers to express and experience in certain situations.

Hochschild (1983) further argues that this display of emotions is either expressed with genuine emotions or by *surface acting* or *deep acting. Surface acting* is when individuals simulate emotions differing from the ones they experience at that very moment, by carefully giving verbal and nonverbal cues. *Deep acting* however, involves attempting to experience or even feel the emotions one wants to display. In that sense, the service provider can be perceived as a performing actor, sometimes required to ignore their true feelings and act as expected, often in front of the critical audience of customers or patients. This description of the concept is further explained by Gardner and Martinko (1988) and Grove and Fisk (1989) who describe *emotional labor* as a form of impression management, to the extent that the laborer deliberately attempts to direct his or her behavior toward others, in order to foster both certain social perceptions of themselves and a certain interpersonal climate.

Ashforth and Humphrey (1993) further expand upon Hochschild's (1983) argument. They define *emotional labor* as the act of displaying appropriate emotions in appropriate situations, in other words following the *display rules* of their profession. They argue that their approach is preferable

since it emphasizes behavior by referring to *display rules* instead of *feeling rules.* They further argue that this distinguishes the feelings actually felt from the behavior carried out by the service providers, since their behavior is easily noticed by external parties. In other words, clients or patients are not able to really know which feelings are actually felt by the service provider but they are however able to recognize their behavior. Accordingly, the way in which service providers behave (adhere to *display rules*) affects service recipients to a greater degree since they do not necessarily know how the service provider actually feels (adheres to *feeling rules).* Additionally, they argue that individuals might follow the *display rules* connected to their profession, without necessarily needing to manage their feelings. We therefore argue that it is of great importance to investigate how the *emotional labor* involved in nursing work affects pediatric nurses, by reviewing literature on the implications of *emotional labor* within a professional context.

2.2.2 The Negative Consequences of Emotional Labor

On the other hand, numerous scholars have discussed the possible negative outcomes of emotional labor (Bolton & Boyd, 2003; Hochshild, 1983; Ashforth & Humphrey, 1993). Since the service providers are expected to feel and act in a certain way, attempting to follow these rules and expectations can cause them distress (Bolton & Boyd, 2003). Hochschild (1983) discusses how the constant tension and mismatch between one's true feelings and the feelings they are expected to display can cause e*motive dissonance. Emotive dissonance* is a term used to describe when there is a discrepancy between the emotions required and actually felt and has been established as a strong predictor of diminished mental wellbeing and increased rates of sick leave (Indregard et al., 2018). This is further supported by Ashforth and Humphrey (1993) who mention that emotive dissonance can lead to: "personal and work-related maladjustment, such as poor self-esteem, depression, cynicism, and alienation from work" (pp. 96-97). This occurs since altering one's personal emotions to match the emotions expected, workers often convince themselves that they feel what they are supposed to feel and turn to *deep acting*. *Deep acting* may eventually lead to self-alienation since the actor can lose touch with their authentic self, resulting in an impaired ability to recognize or experience genuine emotions. Hochschild (1983) discusses that even though the emotive dissonance is perhaps overcome, it comes at the cost of self-alteration. They further present three questions which present the personal struggles *emotional labor* brings along: (1) How can I feel really identified with my work role and with the company without being fused with

them? (2) How can I use my capacities when I'm disconnected from those I am acting for? (3) If I'm doing deep acting for an audience from whom I'm disconnected, how can I maintain my self-esteem without becoming cynical? (Hochschild, 1983, p. 132). These questions highlight the difficult dilemmas service providers face when carrying out *emotional labor* as they emphasize: (1) the fear of merging one's personal and professional identity, (2) the concerns of being able to adhere to the behavior expected of them, and (3) the fear of becoming cynical. To navigate within these pressures to identify with their professional role, service providers make use of coping strategies to relieve themselves (Hochschild, 1983).

Hughes (2010) further discusses the dilemma involved in emotional labor by describing how service providers are expected to be emotionally honest and authentic while developing and managing their true emotions. An additional negative consequence of *emotional labor* is that workers become *"*more vulnerable to the stressors and strains of multiple roles*"* (Wharton & Erickson, 1993, p. 483). This can prove to be difficult since differentiating between private and professional life is not always possible. Emotions, behaviors, and stress are often carried home from work and vice versa and consequently, affect each other. Partly due to the fact that when surface acting at work, individuals often tend to continue acting when at home since that is often the easier choice, as navigating between different roles can be demanding and emotionally draining (Sanz-Vergel et al., 2012). This is further supported by Smith et al. (2021) who present a nurses' description of how the emotional burdens involved in their work can affect their personal relationships. As discussed, *emotional labor* can have various negative consequences. It is therefore important to investigate *emotional labor* in relation to nursing work, to understand which implications it can have on their wellbeing.

2.2.3 Nurses and Emotions

In order to understand the *emotional labor* involved in nursing work, we reviewed literature and relevant research discussing the influence and consequences of *emotional labor* in the context of nursing work. Nurses are in fact one of the most frequently studied professions in the context of *emotional labor* (Henderson, 2001; Lopez, 2006*).* Smith et al. (2021) further argue that regardless of the type of nursing work, it is of interpersonal nature involving interpersonal relationship building with clients, colleagues, etc. which consequently leads to the high degree of *emotional*

labor involved in their work. Bolton (2000) describes how nurses often refer to their display of emotions as masks or faces, which they put on to hide their true feelings of stress, sadness, or anger. As discussed, the frame for *emotional labor* is partially set by common understandings and expectations. For nurses, these expectations involve that they should be compassionate towards patients and their families, but at the same time, avoid public acts such as crying (Cain, 2012; Mann, 2004). Working in an environment that involves such a high degree of emotional involvement enables nurses to be informal, allows emotional exchange, and encourages support among colleagues, which Bolton and Boyd (2003) mention as positive aspects of *emotional labor.* Additionally, the display of expected emotions during service encounters can facilitate task effectiveness and self-expression amongst service providers (Ashforth & Humphrey, 1993). To summarize, the implications and negative outcomes of *emotional labor* are highly relevant to our research since pediatric nursing involves a good amount of *emotional labor.* As discussed, the implications of *emotional labor* can lead to depression, cynicism, and poor self-esteem, often resulting in sick leave. Therefore, it is relevant to further clarify and review literature regarding how the combination of *emotional labor* and *professionalism* within the nursing profession plays out.

2.3 The Nurse as an Emotional Professional

2.3.1 The Combination of Emotional and Professional Work

A general consensus among patients is that nurses are expected to feel empathetic and supportive (Ashforth & Humphrey, 1993). At the same time as they are expected to manage their emotions experienced when interacting with patients and their families, they are also expected to fulfill the professional aspects of their role, such as taking care of clinical tasks and decision making (Bolton, 2000). We therefore find it necessary to investigate further how the nature of *professional work* and the expectations of *professionalism* contrasted with the emotionality of their work affects pediatric nurses. Smith et al. (2021) argue that when investigating how nurses' work depletes their wellbeing, it is important to understand what nursing work entails. They make use of Allen's (2014) definition of *organizing work* which involves information seeking, making sense of complexity, communication, and the use of information technologies. Smith et al. (2021) further argue that nurses are often overwhelmed on a professional and personal level due to the:

> …lack of tools at the individual, relational and organisational level to deal with emotions therapeutically when witnessing the suffering of patients and relatives added to the demands of the organisation, and deterioration in the quality of care (Smith et al., 2021, pp. 267-268).

Smith et al. further describe that despite the professionalization of the nursing role, nurses often express how they lack the power to influence certain aspects of their job. At the same time, they are the healthcare professionals that interact the most with patients which consequently leads to them establishing relationships with them and their families to a greater extent. The essence of this fusion is captured by a nurse stating that most of the time patients complain about: "systems and structures far beyond nurses' scope of influence, yet they remain the face of these systems; all the responsibility with none of the power" (p. 267).

2.3.2 Managing Boundaries

Due to the emotional labor involved and relationship building with clients, the boundaries between acting emotionally and professionally are not always clear. When attending nursing school, nurses learn how they should act *professionally,* and their workplace also sets professional procedures and boundaries which they are expected to follow. However, learning how to respect these professional boundaries is seldom taught (Maguire & Price, 2007; Buder & Fringer, 2016). The combination of these professional and emotional tasks can therefore cause nurses distress to a greater extent. Since the management of professional boundaries are especially hard to manage within pediatrics, we agree with Erikson and Davies (2017) who argued that further research is required regarding how the management of professional boundaries within pediatric nursing plays out. Therefore, we argue that there is an opportunity to contribute empirically to the subject of not only how pediatric nurses manage professional boundaries due to the emotionality of the work, but also how it affects them. Furthermore, we argue that there is limited qualitative material available discussing how these previously mentioned expectations affect pediatric nurses and how they navigate within them. In conclusion, navigating between different identities, being professional at the same time as emotional, creates an identity struggle of some sorts.

2.4 Identity & Identity Work

2.4.1 Identity

In order to fulfill the purpose of the research, we need to investigate how the working environment affects the self-image amongst pediatric nurses. It is therefore of importance to introduce the concept of identity. Identity can be understood as a constructed concept, which cannot be described with an objective amount of characteristics since the person itself and the surroundings contribute to creating meaning of the concept (Alvesson & Billing, 2011). In other words, the concept of identity is hard to define, and there are many definitions of the concept (Harrison & Leitch, 2018). Alvesson and Billing (2011) argue that identity is personal, yet is developing, expressed, and changing in a social and cultural context. Although identity is created through interactions with others, identity is personal, and it is the personal identity that makes one person experience a certain situation differently from someone else (Billing, 2006). Furthermore, both external and internal forces merge and construct individual identities (Sveningsson, Gjerde and Alvesson (2021). Professional standards, organizational cultures, and societal expectations act as external forces and thus affect personal identity construction processes (Alvesson & Sveningsson, 2011; Clarke, Brown, & Hope Hailey, 2009; Knights & Clarke, 2014; Koveshnikov, Vaara, & Ehrnrooth, 2016). McAdams' (1993) concept "life-story" explains how individuals create their identities by aligning these potentially contrasting demands and expectations. This multitude of changeable and sometimes *contradictory standards* and ideals occasionally contribute to making identity an ongoing and fragmented project. Sveningsson, Gjerde, and Alvesson (2021) elaborate further on McAdam's (1993) findings and contrast this fixed life story, and argue that it involves constant adjustments, depending on which contexts trigger the identity work. Identities are multiple and associated with a context (Alvesson & Billing, 2011; Sveningsson, Gjerde & Alvesson, 2021). A person could thus for example be both an effective manager and a loving family member at the same time. This multitude of changeable and sometimes contradictory standards and ideals occasionally contributes to making identity an ongoing and fragmented project (McAdams, 1993). This is interesting since nurses are expected to have several identities when working and should thus be investigated further.

Researchers claim that identity can be divided into three categories: qualitative, numeric, and generic (Fink, 1991, cited in Brinkmann, 2008). Qualitative identity means that one is subjectively

alike someone or something, whereas quality refers to the qualities one possesses. If these qualities are identical to someone or something else, the qualitative identity is thus created (Billing, 2006; Brinkmann, 2008). Numeric identity is connected to one's self-image and whom you think you are (Billing, 2006). The generic identity is different from the other two as it is about being aware of the specific categories in society one belongs to. Fink (1991, cited in Brinkmann, 2008) explains this as if one has a connection to a certain community.

In order to fully understand the identity struggles arising within pediatric nurses, it is important to define what the term *professional identity* entails. *Professional identity* is acknowledged as a crucial component of how professionals make meaning of their lives (Kyratsis et al., 2017; Nelson and Irwin, 2014; Pratt et al., 2006). Chreim, Williams & Hinings (2007) define *professional identity* as: “an individual’s self-definition as a member of a profession and is associated with the enactment of a professional role” (p.1515). A key component of *professional identity* is the strong relationship between professionals' view of themselves and the profession they belong to (Pratt et al., 2006; Reay et al., 2017). *Professional identity* tends to remain relatively stable and difficult to change (Abbott, 1988; Chreim, Williams & Hinings, 2007). This is partly due to the specialized knowledge required which is reinforced not only through executive actions but also through socialization processes (Freidson, 2001). The professionalization of professions results in the professional identities being deeply felt by individual professionals (Ashforth et al., 2008; Mitchell and Boyle, 2015; Molleman and Rink, 2015).

As described, it is the social interactions and experiences that create an identity of an individual. Billing and Alvesson (2011) describe that these interactions and experiences change over time, but could also change quickly, for example during a workday where you meet a lot of different people and encounter different kinds of situations. For this reason, an active effort is required to create and maintain the identity in a complex social world, something that is known as identity work. However, we argue that the part in which the organizational context plays in affecting personal experiences of identity for pediatric nurses is lacking in previous research. Therefore, we acknowledge an opportunity to examine how pediatric nurses build, use, and alter their professional and personal identities within their workplace.

2.3.2 Identity Work

Identity work has been mentioned in the social sciences for the last decades, but only to a certain extent. Alvesson and Willmott (2002) and Sveningsson and Alvesson (2003) conceptualized the concept in the early 2000s and since then various researchers have engaged with the topic, it is described to be an established concept that can be used in many different contexts. Alvesson and Willmott's (2002) conceptualization of identity work can be summarized as an ongoing interpreting activity that contributes to reproducing and transforming the personal identity. Similarly, Sveningsson and Alvesson (2003) claim that people continuously engage in shaping, maintaining, and strengthening the image of a coherent and distinct identity. Alvesson and Billing (2011) confirm previous research and point out that identity work is meant to create a positive self-esteem and self-image. A coherent, distinct and positive self-image is needed when handling the ambiguity of life, different working situations, and relationships (Alvesson & Billing, 2011). Ybema et al. (2009) claim that identity work is about the conversation between internal ideas, wishes, and feelings, and external images and analyses. Identity work is thus triggered in situations where the personal identity is being questioned, or when input from the social environment is threatening the self-concept (Alvesson & Sveningsson, 2016; Eilam & Shamir, 2005), which can happen due to many reasons such as self-doubt, unsafety or resistance. It can also occur in more neutral situations that question personal identity (Alvesson & Billing, 2011). Lutwak, Ferrari & Cheek (1998) further found guilt to be an additional factor affecting one's personal identity. In other words, identity work could be seen as a continuous activity for individuals. Identity work can be said to be emotional, as a questioned identity results in uncomfortable feelings such as frustration and anxiety, resulting in the individual questioning their identity further (Hay, 2014). Hay (2014) claims that not only can emotions not be detached from identity work, they are crucial components for the activity itself. Eilam and Shamir (2005) further argue that identity work increases individuals' self-esteem, individual development, and self-renewal. With that being said, something that can threaten the self-image can also be an opportunity for self-renewal, turning something negative to positive (Eilam & Shamir, 2005).

In a fragmented world, involving contrasting ideals and demands, individuals occasionally participate in intense identity work (Knights & Clarke 2014; Petriglieri, Ashford, & Wrzesniewski, 2019; Sennett, 1998). This is further supported by Collinson (2003) who describes how answers

regarding whom you believe you are less straightforward when the environment involves high levels of flexibility and negotiation. Most identity research further suggests that identity questions are generally brought about at times of feelings of inadequacy, anxiety, uncertainty, and complexity, for instance, since individuals may participate in an active search to stabilize and reconstruct their identities (Sveningsson, Gjerde & Alvesson. 2021). Thus, in complex situations, individual identities become challenged to a greater degree and fragile (Brown & Coupland, 2015). A discrepancy between the external or internal ideals and standards connected to one's role thus acts as a challenge to maintaining a coherent identity. In such times, the need for confirmation or validation from others acts as an important aspect of identity work, as it reinforces one's identity. However, when these identity claims are rejected, challenged, or even ignored by others, it can affect the establishment of the individual identities negatively (Sveningsson, Gjerde & Alvesson, 2021).

Ashforth and Johnson (2001) further mention how professional workers are often forced to navigate between multiple identification demands which vary from one another. When one's personal identity does not match with the collective identity of the group one belongs to, these identities compete with one another and can in turn cause internal conflicts, resulting in a clash (Scott, 1997). This is not always the case since different identities can be compatible or enhance one another (Ramarajan, 2014). Sveningsson and Alvesson (2016) present five somewhat overlapping outcomes of attempts to maintain a positive and coherent identity; *identity adjustment, identity expression, identity juggling, identity wrestling,* and *identity crash. Identity wrestling* is explained as a problematic form of identity work, as opposed to *identity adjustment* which refers to minor frictions and *identity expression* which involves reinforcing identity rather than identity frictions and conflicts. They describe *identity wrestling* as: "the way in which the individual's self-view is only mildly confirmed by others or by their own achievements and is therefore in danger of being undermined" (p. 255). *Identity wrestling* thus represents a moderately serious form of identity struggle, since it is more severe than *identity juggling* but less extreme than a total *identity crash.* Furthermore, they argue that individuals are forced to engage in intensive identity work to be able to maintain, repair, reinforce or revise their self-view in this discouraging social situation. If that does not prove to be possible, it could result in *identity crashing,* where an exit of some sorts is often the only way to recover. Thus, *identity wrestling* is characterized by the highs and

lows involved, which many individuals experience for longer periods of their working lives. Especially now, during times when different ideals are constantly communicated, discrepancies between ideals and realities can easily occur, burdening one's identity and perhaps resulting in worse self-esteem (Alvesson, 2013).

Sveningsson and Alvesson (2016) further discuss how managers deal with these identity conflicts using various coping mechanisms such as decoupling, fantasies, and hopes for the future. Decoupling is described as creating separate managerial identities to keep conflicting forces apart, which leads to friction but if successful has the ability to ease the struggle and consequently, prevent collapse. Fantasies however refer to creating imaginative and attractive images of oneself, reinforcing one's preferable identity, and making it possible to keep it separate to some degree from their practical work (Sveningsson & Larsson, 2006). Hopes for the future are especially common in relation to *identity wrestling,* since dreaming of brighter days can help one deal with the present tensions and difficulties (Sveningsson & Alvesson, 2016). They discuss this in relation to managers, we however argue that these kinds of identity work are not limited to managers and that they are applicable in the context of pediatric nurses. Therefore, we make use of the theory presented by Sveningson and Alvesson (2016) and believe that we can contribute empirically to the understanding of how *identity wrestling* and attempts to maintain positive and coherent identities play out in the context of pediatric nursing.

3 Methodology

In the following chapter, the execution of the study and its methodological choices will be presented and argued for. Firstly, the ontology and epistemology of the study will be presented. The reasoning of the research process will then be argued for, followed by an explanation of the empirical data collection. Finally, the quality of the study will be declared.

3.1 Research Approach

3.1.1 Ontology & Epistemology

In order to answer our research question, we want to investigate the experiences and perceptions of the interviewees' social context. Accordingly, we have chosen to use a qualitative research strategy. Qualitative research aims to understand different concepts, phenomena, or experiences rather than numbers, and the interest is thus in describing the social world that is being investigated (Bell, Bryman & Harley, 2019). Additionally, there is a great focus on finding a depth in the material rather than a width in qualitative research. We have chosen the ontological position of social constructionism. This ontology refers to social phenomena and their meanings being "continuously accomplished by social actors" (Bell, Bryman & Harley, 2019, p. 27). Put differently, social actors are constantly constructing their own social reality which is thus also constantly being revised. Social constructionism does not view different phenomena as something objective, but rather as socially constructed by individuals' experiences and understandings. There is thus no objective truth (Alvesson & Sköldberg, 2018; Bell, Bryman & Harley, 2019). The epistemology used in this research could be described as interpretative. The interpretative epistemology is based on that both knowledge and reality are socially constructed and rely on interpretations made by humans, attached to their actions. Reality is thus not tangible and only exists in human consciousness (Prasad, 2018). Interpretivism is in other words strongly associated with the ontology of social constructionism and could thus be used together.

This premise has thus shaped our research and guided us in how to go about throughout the research process. We have thus had a focus on understanding how the participants of our study, the nurses, perceive their own social reality. In our case this means interpreting how pediatric nurses experience and perceive their own social reality, and the social reality's perception of them

as nurses. It is important to mention that this research approach also means that we as researchers and authors have our own perceptions regarding our social reality, which differs from each other and is thus not objective. The findings of our research are thus dependent on our interpretations, which depend on how we perceive our social world. The findings presented are thus not an objective image of the phenomena, but rather a description of our socially constructed perception of the nurses' individual perceptions of their social reality.

3.1.2 Abductive Approach

Research within the business field stems from either inductive or deductive reasoning, meaning different ways to work with theory and empirical findings (Bell, Bryman & Harley, 2019). In deductive reasoning, the researchers first create hypotheses based on theories that are tested in the study and then either accepted or rejected. Inductive reasoning could be seen as the opposite of deduction as it looks at empirical observations that can be theorized and added to the already existing literature on the subject. However, Bell, Bryman, and Harley (2019) argue that "deductive and inductive strategies are (...) better thought of as tendencies rather than as a hard-and-fast distinction" (p. 24). Moreover, both deductive and inductive reasoning have disadvantages such as it being unclear which theory should be chosen or how much empirical material is needed to be able to theorize (Bell, Bryman & Harley, 2019). These disadvantages are argued to be avoided by using abductive reasoning instead of the other two (Alvesson & Sköldberg, 2008; Bryman & Bell, 2017).

Abductive reasoning is described as a method to "make logical inferences and build theories about the world" (Bell, Bryman & Harley, 2019), similar to inductive and deductive reasoning. Abductive reasoning involves finding recurring and interesting phenomena in the empirical material which cannot be explained by the already existing research that has been done on the subject. One, therefore, aims to find solutions and explanations to these phenomena through a pendulum movement between the social world as the empirical source and the existing literature (Bell, Bryman & Harley, 2019). The pre-existing literature can be seen as a source of inspiration that can be used by the researchers to increase their understanding of the analysis process (Alvesson & Sköldberg, 2008). The focus is thus switching between the empirical and theoretical material, where one can reinterpret the other to change the direction of the study. Mantere and

Ketoviki (2013, cited in Bell, Bryman & Harley, 2019, p. 24) explain that interpretative research is theory created through a dialogical process between theoretical and empirical phenomena, which is strongly connected to the abductive reasoning.

The reason for why we chose to make use of the abductive reasoning was that we considered this to aid us in securing a deeper understanding of our chosen subject. Originally, we sought to investigate the working environment of pediatric nurses and how this affected their mental health. Both authors have knowledge in the areas of the working environment and mental health but were lacking knowledge in the area of nursing and the medical industry. Accordingly, we could educate ourselves within the area with the existing literature, to be able to gain a deeper understanding of the nurses' experiences. When the collection of empirical data began we gained more awareness, and the phenomena that were found made us change the direction of the theory, which made us investigate the topic of guilt connected to the work environment and mental health. When the empirical gathering was finished, we realized that we needed to broaden the theory again, and switched the theoretical focus to professionalism and identity amongst the nurses. In other words, the pendulum movement was evident in our research process, as the theory was revised depending on the findings in the empirical material. The abductive reasoning thus enabled a greater understanding, as we could reinterpret both the theory and the empirical material.

3.2 Empirical Data Collection

3.2.1 Selection Process

In order to collect data to study the desired topic and answer our research question, we went through a selection process to find suitable interviewees. The interviewees were found by purposive sampling, which is a way of actively finding relevant participants for a specific study (Bryman & Bell, 2017). After we had decided on the topic we wanted to study, we used our network to start the selection process. We could reach the manager of a Swedish hospital, who connected us with the pediatric unit of this specific hospital. The pediatric unit was chosen due to its complexity and emotional aspects of work, and nurses were the desired role as this role includes a great amount of contact with the patients. We could then continue our selection process by using criterion sampling (Bell, Bryman & Harley, 2019), where the criteria we decided on were nurses and assistant nurses working in the same department, that is the pediatric unit at the Swedish

hospital. E-mails with a short presentation of us as researchers and the theme of the study were sent out to all unit managers within pediatrics, who forwarded it to their nurses as a request to partake. In order to affect the interviewees as little as possible, we chose to not communicate any major information regarding the study, apart from the theme of working conditions within pediatrics. Four nurses got back to us via email and chose to participate in the study. In order to get hold of more interviewees, we visited the hospital, and the unit manager arranged four more meetings for us with two nurses and two assistant nurses. All eight interviewees were considered to be relevant as they seemed to reflect the whole group of employees: some were newly graduated and some had been working at other units before; some had been at the unit for just a few months, and some for many years; there were also both nurses and assistant nurses. Nevertheless, when using purposive sampling one cannot generalize the conclusions for the whole population of nurses (Bell, Bryman & Harley, 2019), we can solely draw conclusions based on the interviewees' perceptions of their social world. Yet having interviewees that reflected the whole unit was important to us as it would provide a more nuanced picture of the case.

3.2.2 Description of the Case Context

In order to gather information about the case context, other than what was obtained through research on literature and the interviews with the nurses, an interview with the unit manager was arranged. This allowed us to understand how this specific unit was run which was necessary in order to get a better understanding of the nurses' perceptions and experiences.

The data collection took place at a pediatric unit of a Swedish hospital, located in a Swedish city with a population of 50 000-100 000 people. The pediatric unit employs approximately fifty employees, the majority being female. Roughly half the workforce are nurses, and the other half are assistant nurses. The nurses and assistant nurses are of varying ages and have different prior experiences. Some are newly graduated and started in pediatrics immediately, others have worked as a nurse for a few years and have tried working at other units of the hospital, and some have been working their whole career in the pediatric unit. They work in teams of two, one being a nurse and one being an assistant nurse. They thus share the same patients, and they usually do not have that many patients per team when compared to other units of the hospital. The unit is an around-the-clock organization and being a nurse at the pediatric unit entails long hours and a high workload.

Their shifts are scheduled in accordance with their contract, which could be either part-time or full-time, but they are expected to be able to take on both day and night shifts, both on weekdays, weekends, and holidays. Additionally, the nurses are expected to take on extra shifts and could be ordered to come in even if they have other plans. It is not uncommon for nurses to take on double shifts or not have the time to go home in between shifts. At the same time, the wage is low, meaning that the nurses need to work a lot in order to get a decent salary. Many of the nurses have the opinion that there is a shortage of nurses, but the unit manager explains that they have never had as many nurses employed at the unit as they have at the moment, but that many are on sick leave or parental leave. Furthermore, there is a lack of nurses in the overall workforce, meaning that there is no quick fix to the problem of hiring more nurses.

The unit provides emergency treatment, scheduled appointments, long-term care, daycare, and guidance. The patients come in for a variation of issues, everything from asthma to gastronomic illnesses to cancer. For these reasons, the number of patients can vary from day to day, and the unit needs to collaborate with doctors and specialists from other units, who come by every now and then. The ages of the patients vary from neonates up to young adults under 20 years old, and most of the patients have at least one parent present at all times, and families are often present as well. Accordingly, nurses and assistant nurses spend a lot of time with patients and their parents and families, and naturally, strong relationships are built over time. Having children as patients increases the pressure on the nurses, as they have responsibility for their care, ensuring a good recovery, and thus having the responsibility of a child's life.

Below is a summary of the nurses participating in the study:

Alias & Position	Age	Type of Employment	Time at the Pediatric Unit	Length of the Interview	Number of Pages Transcribed
Nurse A	33	Part-time	6 years	1:17:05	25
Nurse B	28	Full-time	1.5 years	0:35:55	12
Nurse C	22	Full-time	2.5 months	0:19:05	8

Nurse D	28	Full-time	2 years	0:22:03	7
Nurse E	33	Part-time	12 years	0:51:08	19
Nurse F	65	Full-time	20 years	0:41:40	14
Assistant Nurse A	20	Full-time	1 year	0:23:28	8
Assistant Nurse B	32	Full-time	5 years	0:19:59	7

Table 1: Participating Nurses

3.2.3 The Interview Process

We chose interviews to collect our empirical data as this contributes to a depth of the answers and getting the interviewees' own perception of the topic (Bryman & Bell, 2017). Kvale (2015, cited in Rennstam & Wästerfors, 2015, pp. 28-29) argues that interviews are a good choice of data collection as it provides a versatile image of the interviewees' perception of their social context. The collection of data was thus made through eight qualitative interviews with nurses and assistant nurses at the pediatric unit of a Swedish hospital. The interviews were semi-structured, meaning that the interviews were structured by having a set of themes for the questions, but the questions could be asked in a different order every time, and the interviewee gets a lot of freedom in how they want to answer the question (Bryman & Bell, 2017). We followed an interview guide to cover certain areas and themes: background information, working environment, the nurse profession, and mental health (See Appendix A & B). The questions were as open as possible, and not theory-driven, to allow us to analyze the answers without the theoretical constraints. This type of interview is flexible, leaving room for suitable questions and follow-up questions to get as clear answers as possible, without being leading (Bryman & Bell, 2017). To make the interviewee feel as comfortable as possible, we aimed to make the interview seem more like a conversation rather than an interview.

Seven of the interviews were held on-site at the hospital, where we sat in a separate room with the interviewee without disturbance from other employees or patients. One interview was done

through a video call over Zoom, where the interviewee was sitting in an office at the hospital. The nurses were in other words all in their working gear, and in between shifts, which made it possible for us to see them in their natural habitat. Both authors of the study participated together in all interviews except one, to ensure an in-depth interview, where one could fill in if the other missed something, and more aspects and nuances of the interview were enabled. One of us had a leading role in the interview and was in charge of making sure that the interview guide was followed, whilst the other one helped with follow-up questions and was observing the mimicry and gestures of the interviewee. The interviews lasted for 20-90 minutes, depending on both when saturation of the answers was reached, and how much time the nurses had to spare. With the approval of the interviewees, each interview was recorded with the help of a voice recorder on a phone. This recording was then played, and Microsoft Office Word's function "dictate" helped us transcribe the interviews. The transcriptions were then carefully read through while at the same time listening to the recording, ensuring that the transcriptions were correct. This also allowed us to early on in the process "spend time with the material" (Rennstam & Wästerfors, 2018, p. 83). The transcription process is of high importance as the analysis is based on the experiences of the interviewees and having it word by word makes it possible to get a deeper analysis of the data (Bryman & Bell, 2017). Altogether we had 100 pages of transcribed material.

We guaranteed the participating nurses and assistant nurses anonymity and informed them that we would use the level of profession, employment type, age, and how long they had worked within pediatrics, as this was considered to be necessary to understand the empirical data and subject overall. It was important for us to guarantee the nurses' anonymity as the subject of mental health, as well as sharing information about patients is very sensitive. The anonymity acted as a safety for the participants of the study as they could speak freely and be descriptive about their experiences for us to gain a deeper understanding. We have chosen not to include quotations made about specific patients or cases to further strengthen the anonymity of the nurses and the study. The location of the interviews further strengthened the feeling of security for the nurses as we were sitting in a room without disturbance, however, perhaps they would have felt even more safe and free if we were not at the hospital. After the interviews, we have had the opportunity to reach out to the interviewees for clarifying questions to make sure that the answers given have been interpreted fairly.

3.3 Analysis Process

In order to work with the transcribed empirical material from the interview we made use of Rennstam and Wästerfors' (2015) method regarding how to analyze qualitative research. They argue that when analyzing qualitative material, there are three problems that often appear: the problem of chaos, the problem of representation, and the problem of authority (Rennstam & Wästerfors, 2015). Following the steps of sorting, reducing, and arguing is suggested as a solution to these problems. Moreover, it also aids in making the material easier to work through, sorting out interesting parts, and identifying recurring themes in the interviewee's experiences. We chose this method of analyzing as the flexibility in it was seen as beneficial for the abductive reasoning we had chosen to work with. Furthermore, it is a method that could develop the quality of the study as it is systematic with clear steps to follow. We could therefore be confident that the analysis would be thoroughly dealt with, and prepare us for theorizing the material for the analysis and discussion.

3.3.1 Sorting

The first problem that one might come across when working with the analysis of the empirical material gathered is the problem of chaos (Rennstam & Wästerfors, 2015). This problem is caused by the amount of data gathered. Qualitative material is extensive, and it could be difficult to grasp. In order to avoid this problem, one can work by sorting the data, to create an overview and clarity of the material.

The first step in the sorting stage is to spend time with the collected empirical material (Rennstam & Wästerfors, 2015). As previously mentioned, this process started early on as we thoroughly worked through the transcriptions of the interviews continuously throughout the data collection stage. We thus spent time with the material by reading it several times and discussing the content with each other. Rennstam and Wästerfors (2015) argue that this stage is important as one will understand how to navigate between the interviews you have made. We thus got an understanding of how one interview was related to another and had the opportunity to find new points of view and nuances every time the material was worked through. The sorting was based on recurring and deviating content which could possibly be proof of certain phenomena. In order to find these parts

of the material, we worked with Gubrium and Holstein's (1997) theory regarding whats and hows. By sorting the material from whats and hows, one will be able to analyze it on a deeper level. This made it possible for us to discuss *what* was being said, both implicitly and explicitly, but also *how* it was said, where you investigate the way something is being said rather than the content of what is being said. Gubrium and Holstein (1997) argue that it is the question of *how* that constitutes social constructionist research where a phenomenon is explained, and the combination of the *whats* and the *hows* gives you the answer to why something is. In other words, this way of working with the material was considered appropriate for our study, as we wanted a strong and deep analysis of our interviewees' experiences and perceptions.

Throughout the process of sorting, the empirical material was sorted many times in order to find different ways of proceeding. Firstly, we sorted the recurring and deviating content into four different categories that we perceived to be the most obvious direction: the healthcare industry, workload, and stressors, working with children, and work environment. The statements of the different themes were then pasted into a separate document, providing a better overview of the data. Furthermore, it allowed us to move the quotations around according to the patterns and the deviations that were found. We got a good overview of the material, and which statements were linked, yet considering that all data was included in the sorting, the data under each category was still very cluttered and disorganized, and the categories seemed too apparent and only focused on the *what.* We, therefore, decided to sort the material again, in order to find less apparent parts of the material. Rennstam and Wästerfors (2015) explain that the researchers should stay independent and look in the periphery, at what at a first glance seems unimportant to be able to make more original interpretations. The second sorting was divided into more specific categories that were based on both *whats* and *hows*. This was done in the online tool Padlet, and it resulted in thirteen different categories. By doing this we could also get an understanding of which categories were the most original and which quotations were the strongest, which further helped us when reducing the material. Throughout the process, we have tried to stay objective and keep an open mindset towards our material in order to not be constrained by our prior perceptions and understandings. By sorting the material in different ways, we have thus found a way to make the material justice.

3.3.2 Reduction

The next problem that Rennstam and Wästerfors (2015) address is the problem of representation. This means that the researchers need to realize that due to the amount of data collected, not all data can be presented in the study. Therefore, the researchers need to find parts of the material that can represent and reflect the material as a whole. These parts should thus be an example of different phenomena found in the data, in order to reduce the data and make it manageable for the presentation.

To reduce our material, we started by looking at the categories created in the online tool Padlet, as mentioned in the previous section. This way we could get an overview of the material and the different phenomena that could be identified. We could then find which categories were the strongest and that illustrated the situation and phenomena the best. Therefore, we disregarded a large portion of the categories that were found in the sorting stage and ended up with six different categories: unstandardized work, presence of the parents, the responsibilities and fear of making mistakes, being a parent and a nurse, the feeling of guilt, and coping mechanisms. This reduction can be described as a categorical reduction (Rennstam & Wästerfors, 2015). Thereafter the most illustrative quotations for each category were chosen, accompanied by shorter supporting quotations. After having written a draft of the analysis we turned to theory to aid in the thematization of the categories we perceived reflected the nurses' experiences, as well as to investigate which categories that would complement existing theory the best. There we found that the phenomena that we wanted to highlight were the balancing act of professionalism and emotions in the workplace. We, therefore, decided that the categories of unstandardized work, the responsibility and fear of making mistakes, the feeling of guilt, and coping mechanisms were the strongest themes, and the other two categories could be used to support the other themes as they had overlapping content. This type of reduction could be described as illustrative reduction (Rennstam & Wästerfors, 2015) which is making a phenomenon visible by disregarding other phenomena.

Throughout the reduction stage, we were careful and humble about the material we had gathered. Rennstam and Wästerfors (2015) explain that the researcher should be prepared to revisit data that has already been disregarded in order to make the material justice and to reflect the rest of the

material in the best way. This could be done since we had already spent a good amount of time with the data, that we knew when we had statements that could complement new findings, even if we had disregarded them at a previous stage. We consequently felt confident in the selection of data to be presented as it represented the whole material, with some of it being described in detail, and some were left to just support the rest.

3.3.3 Building Arguments

The last problem that one could come across when analyzing qualitative material is the problem of authority (Rennstam & Wästerfors, 2015). This is defined as the difficulty in asserting your work and your point in regards to other researchers. One, therefore, needs to be confident in the point that is being made and argue for its relevance. Rennstam and Wästerfors (2015) argue that theorizing is a part of the arguing stage, and that the empirical data should be presented in a theoretical manner. The empirical data thus acts as the examples used to strengthen the claims one makes.

When working with the material for the analysis we have subconsciously been theorizing through the whole process. We aim to explain our empirical material and have managed to do so by sorting and reducing and creating themes and categories based on theory. In other words, we have theorized by putting forward our empirical material in a theoretical way. The empirical data that is presented both confirms the preexistent theory, but also deviates from it, and is thus presenting new points of view on different phenomena, thus contributing with new theoretical perspectives. By using theories about professionalism, emotional work and labor, and identity we intend to contribute with new perspectives on their interplay within pediatric care.

By using Emerson's (1995, cited in Rennstam & Wästerfors, 2015, pp. 49-50; 148-150) method of creating excerpt-commentary units, we managed to argue for our findings. This method presents four steps in how to formulate an argument that can strengthen the theoretical point: making an analytical point, providing an orientation of the material, an empirical example, and finally an analytical comment. Accordingly, we started with making an analytical point, which is what we want to mediate with the argument, formulated in one or two sentences. Next, we provided an orientation of the material, with an introduction of the empirical material that would be presented

next, to give the reader an understanding of the context and what is happening in this specific example. This was then followed by the empirical example, which in our case was longer quotations picked out in the reduction stage, followed by shorter quotations to support the point. Lastly, an analytical comment was made which analyzed the quotations and summarized what we argued for. This was done under all themes that were found in the reduction stage, to make it as clear as possible. By doing this, we also created a narrative that was easy to follow and built up to our final discussion.

3.4 Credibility, Reflexivity & Limitations

Due to the ambiguity of interpretations within qualitative research, there is a need to discuss how we have worked to ensure the credibility of the study, as well as the limitations of our study. Bryman and Bell (2017) present two common ways to define the quality of a study which are to determine its reliability and validity, however, these ways are mostly applicable to quantitative studies, and one, therefore, needs to examine the quality through other criteria. Alvesson and Sköldberg (2018) thereby argue for the importance of reflexivity and how the researchers' prior assumptions could affect the bias of the research project as a way to determine the quality.

Bryman and Bell (2017) argue that one way of increasing the study's credibility is to go through a validation amongst the interviewees or triangulation. Due to the time limit of the research project, we have not been able to perform a validation of the study with our respondents, which means that the interviewees have not had the opportunity to read through our interpretations of their answers before publication. However, the research project will be sent to all the participants of the study afterwards, which contributes to the credibility to a small extent (Bryman & Bell, 2017). We have chosen a social constructionist ontological position and have thus throughout the research process been very aware of the high level of subjectivity within qualitative research, and that there is no objective truth (Bryman & Bell, 2017; Alvesson & Sköldberg, 2018). Therefore, it has been of great importance to us that we act in good faith when it comes to preexisting understandings and opinions. We have thus continuously reflected on our own opinions and how they could affect our research. By having open conversations regarding our opinions and perceptions of the experiences we have had ourselves, but also how we perceive the interviewees' own perceptions, we have made ourselves aware and allowed scrutinization of each other. In other words, being two

researchers of the study has encouraged reflexivity in all respects of the study, as we have worked through each other's work from a critical point of view, making the study more credible and valid (Alvesson & Sköldberg, 2018; Bryman & Bell, 2017).

The context of our study can be perceived as emotional, both for the interviewees and for ourselves as researchers. Hearing stories about hospitalized children, their parents, and their relationships with the nurses, as well as the nurses' own perceptions of their work is indeed emotional. We, therefore, saw a risk of the emotional nature of the study's context in that it could affect our perceptions of the empirical data that was collected. This risk was addressed as we made sure not to meet any of the sick children or their parents, which made it possible for us to focus only on the stories told by the nurses, making it easier for us as researchers to not be affected by the emotional sides of the context in which we were working. Furthermore, we allowed ourselves to take breaks in between the interviews, to be able to ventilate and let go of the stories that could be perceived as emotional for us personally. By doing this, we found a way in which we could keep our own emotions aside and were thus not a constraint for us in our work. We did however let our previous knowledge and emotions act as a way to make the interviewees feel more comfortable during the interviews, as we could show understanding and empathy to what they were saying.

Bryman and Bell (2017) argue that apart from reflexivity, following clear research methodologies is a strength when defining the study's credibility. We have thus made use of a clear qualitative research methodology in regards to the collection of data, and Rennstam and Wästerfors' (2015) method when analyzing the empirical data. In other words, we have had a clear methodology that has been followed in detail to make sure that the study becomes credible and valid. Nonetheless, in retrospect, we recognize some limitations of our research process which we will briefly elaborate on. The selection process resulted in a selection of only female nurses and assistant nurses, which could be seen as a limitation. Although the nursing profession is a female-dominated profession, interviewing only female nurses could be seen as a one-sided view of the working situation. Moreover, another limitation is that the interviews were held in Swedish, and the quotations were then translated into English which could lead to misinterpretations and loss of nuances. In order to avoid this, we analyzed the quotations in Swedish to make sure that all wordings could be analyzed correctly. Thereafter they could be translated into English. By having

identified limitations of the methodology and discussing how to overcome them is thus a way to be reflexive towards our study, which we have aimed to be throughout the whole research process.

4 Empirical Material & Analysis

In this chapter, we present, discuss, and analyze the empirical material collected. First, we will present the working situation as unstandardized and the implications this has on the pediatric nurses' wellbeing. This is followed by a presentation of the nurses' perception of the responsibility they have, as well as their fear of making mistakes. Thereafter we will present the pediatric nurses' experiences of guilt, and how this affects them. Finally, the nurses' different ways of coping with their working situation will be presented.

4.1 The (un)standardized Work

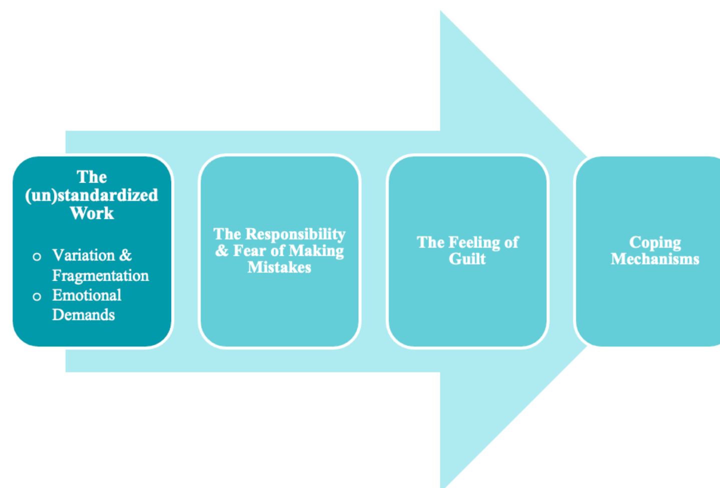

Figure 2: Overview of Analysis - The (un)standardized Work

4.1.1 Variation & Fragmentation

The unstandardized way of working and the uncertainty within the pediatric unit could be understood as a constraint on the interviewees' wellbeing. In their experience, working with children deviates a lot from the standard working environment within healthcare. Therefore, pediatric nurses have to adjust to this way of working, especially when coming from a department with adult patients. This can therefore complicate their working situation, as the work seems to differ from their own expectations of the nurse profession.

> *It's really challenging in many ways. Here we have so many different ages, everything from small babies to young adults. And a lot of different diagnoses and clinical referrals so you have to take care of a lot. So it can be challenging* (Assistant Nurse B).

> *It definitely has more variation to it, both enormous variations and contrasts. I have to be more on my toes and I don't fall into a routine. All visits are not the same and I think it makes me more open to really see the family I have in front of me* (Nurse E).

As described by Assistant Nurse B, the fact that the pediatric unit takes care of *children* can act as an additional stress factor. As stated, the unit takes care of children of varying ages, everything from small children to young adults. This highlights the complexity of the work tasks since taking care of a toddler who can't put their feelings in words can differ a lot from taking care of young adults. Additionally, within the pediatric unit, the patients have different diagnoses with the only common denominator being the age group they belong to. Usually, units within hospitals are organized according to the patients' diseases. Since the unit provides emergency treatment, the nurses perceive that they are expected to know how to treat a greater variety of diseases and patients, which in their experience differs from working within other units within the healthcare industry. This results in the nurses describing their work as *"challenging"* due to the varying nature of cases and thus, the need for individual adjustment and being more alert. This constant need for adjustment could lead to procedures being more time consuming than expected as described by Nurse D and A:

> *The majority takes way more time. Yeah, and maybe you had a plan for how your day was supposed to go, but maybe something happens, and taking care of one patient takes up half of your day. You really have to know, like, how you are supposed to approach specific patients. They can be very scared or have autism or something. Then certain things can take much more time (Nurse D).*

> *Then everything is supposed to be done. It is supposed to be ready. They don't accept that it wasn't really the right timing for taking a test from this child, it was possible, but it*

> *wasn't the right moment for the child. "Yes, but the test results should be ready when I arrive". Yeah, but this is actually a pediatric unit* (Nurse A).

Nurse D explains how the irregularity of working tasks can create uncertainty in regards to what each day will entail. This uncertainty of not knowing what each day will entail could lead to the nurses not being able to plan accordingly, which in their experience differs from the way of working amongst other units within the hospital. Thus, the pediatric nurses explain how they perceive other healthcare professionals from different units are lacking an understanding of the way of working within the pediatric unit. As explained by Nurse A who mentioned how doctors who go between units expect everything to be ready when they arrive. This isn't always possible according to Nurse A who emphasizes the fact that working within the pediatric unit requires further adjustment, patience, and understanding. This is supported by Nurse A who states that *"children are not small adults; children function in a completely different way"* (Nurse A) and thus require a different approach. This leads to the nurses experiencing irritation towards healthcare professionals that lack an understanding of the way of working within the pediatric unit since they are not specialized in treating children. This is further mentioned by Nurse B who describes how taking care of children requires further understanding:

> *…especially those who aren't used to working with children, they do not see it the way it is. That this is actually a child. You cannot talk the same way as you talk to an adult to this five-year-old. It doesn't work, so yeah you have some understanding [of pediatric care]* (Nurse B).

The lack of understanding amongst other healthcare workers could result in the work being interrupted by different types of distractions. Numerous interviewees mentioned this adjustment as something that is difficult to obtain and does not come easily to everyone. As described by Nurse B, stating that you need to have some *"understanding"* and that those who are not as used to working with children *"do not see it the way it is".* This need for guiding external healthcare professionals could act as an additional distraction to the nurses' work. Nurse A describes how these constant distractions from various parties can play out:

> *A lot of people are pulling your arm at the same time. Then the physiotherapist arrives and then the dietician. Like there are so many loose threads in the air all the time which you are supposed to catch and pull. And then you also have the phone constantly disturbing, all the time* (Nurse A).

Smaller additional tasks such as answering the phone, therefore, could act as an additional stress factor as described by Nurse A. Their description of how the phone constantly disturbs with the addition of *"all the time"* indicates that smaller inconveniences added to their already full plate of tasks have the means to upset the employees and thus affect their wellbeing at work.

4.1.2 Emotional Demands

Furthermore, apart from the existing distractions connected to the unit and its routines, as explained above, pediatric care requires parents' presence at all times which can be seen as an external distraction for the nurses. Throughout the interviews, it was clear that this could be seen both as an asset and as a source of conflict.

> *...to meet families with children and to feel that you can help them. And that you are an important part of their lives. Or at least for a small period of their lives* (Nurse D).

Nurse D is talking about being a part of the families' lives when their child is in need of hospital care. This is a strong statement, as being a part of someone's life is a much closer relationship than being someone who is just looking after a sick child. The quotations "*You create strong bonds with the families"* (Nurse A), "*you get a deepened contact"* (Nurse F), and "*you build some sort of relationship with them"* (Nurse C) support this, as they use words like *strong* and *deep* to describe the relationships they develop. These intimate relationships could make it difficult for the nurses to differentiate between their emotions and their role as a nurse. At the same time, this could be interpreted as a threat to the nurses' self-image, resulting in the nurses experiencing the parents' presence as something negative rather than helpful.

*...and then they could be of help, but it really depends... It depends on what the parents are like *long pause*. But I guess it's good that we have the parents here after all* (Nurse B).

You laugh a lot together with the parents and their children, and things like that. Then you also have families where nothing works. It's just shit. Everything is just shit. Everything you do is shit, everything you say is shit (Nurse A).

Nurse B is not convinced about the advantages of having parents present at all times and says that it "*depends"* on the parents and what they are like. It is helpful for the nurses in some ways, but their presence can also lead to problems, and could therefore rather be seen as a speed bump in their work that adds additional stress. Nurse A also has the opinion that it depends on the parents and highlights that sometimes nothing they do is right according to the parents. They use strong language stating that to some parents "*everything is just shit*" and that everything the nurses say or do "*is shit*". Having parents involved in what could be seen as the everyday work for the nurse, but a situation where parents would rather avoid being in, taking care of their sick child at a hospital, can be seen as an additional stress factor to an already stressful work environment.

It's a balancing act to work with communication with the whole family, knowing when to turn straight to the child and when to be general and comprehensive, and when to turn to the whole family and to include everyone (Nurse E).

You need to inform on many different levels in order for everyone to understand. You need to explain it in one way for a child, and in another way for an adult (Nurse C).

I need to meet the parents on their level (Nurse F).

Nurse E, C, and F describe how they need to adjust their communication as pediatric nurses. When your main patients are children, you need to be able to communicate with them about what is wrong with them and what the treatment plan is, in a non-medical language, to make it as comprehensible as possible for the child. However, they also need to communicate it once more

to the parents, and sometimes another time to siblings, who might require another type of language to understand. In other words, it could be interpreted as the nurses feeling like they need to spend twice as much time just informing patients and their families as nurses at other units would need to do. This could be understood as the nurses feeling like they do more than what is required of them as nurses, but they do so to satisfy all parties.

> *Some parents can be pretty mentally demanding to handle, and it's really special when you need to take care of their child. You need to let them be a part of everything, and let them do as much as they can. At the same time, you need to tell them off, or give them pointers and tell them what to do in certain areas* (Assistant Nurse A).

In the quotation above it is clear that Assistant Nurse A sometimes sees the parents as an additional stress factor whilst doing their job. They describe it as "*mentally demanding*". Assistant Nurse B similarly explains that parents could be *"a challenge on its own*" in the job as a nurse. Nurse C describes the parents as "*controlling"*, which has the means to make the work of a nurse much more demanding. The nurses say that a reason for this is that the parents are often "*more worried*" (Nurse D) than the children and that they "*make the children even more stressed*" (Nurse B) as children often copy their parents' behavior. In a like manner, Nurse E says that "*if the parents feel safe, the child will feel safe. The child will copy their parents, both consciously and subconsciously*". Having parents around could thus be understood as a matter of annoyance or obstacle in the nurses' everyday work as they cannot always focus solely on their actual patients.

> *I've been hospitalized quite a bit with my own children, and these are the things you really want to know. You want to feel human* (Nurse F).

Nurse F has another view on the parents' presence as they have experience of being on the other side as well. They, therefore, have an understanding of what the parents feel like, which is something that they are contrasting with being "*human*". One could therefore interpret it as parents need the confirmation and communication from the nurses in order to feel safe. Nurse E explains this by saying that "*Even if our focus should not be on the parents' wellbeing, it matters a lot for the child who the visit is actually meant for"*. In other words, nurses working in pediatrics

experience a need to work a lot more with parents and families than a regular nurse would have to do, which can increase uncertainty for the nurses as they cannot focus properly on their patients.

As discussed in the empirical material analyzed above, the unstandardized way of working challenges the internal and external beliefs of what the nursing role should entail. Which in turn can create uncertainty and fragmentation which can call for adjustment. This variation, irregularity, and disturbance mentioned within the pediatric unit are further combined with the emotional burden of not only taking care of sick children but also their families. This high amount of relationship building, and emotions involved can consequently require additional adjustment which in turn acts as a constraint on the nurses' wellbeing.

4.2 The Responsibility & Fear of Making Mistakes

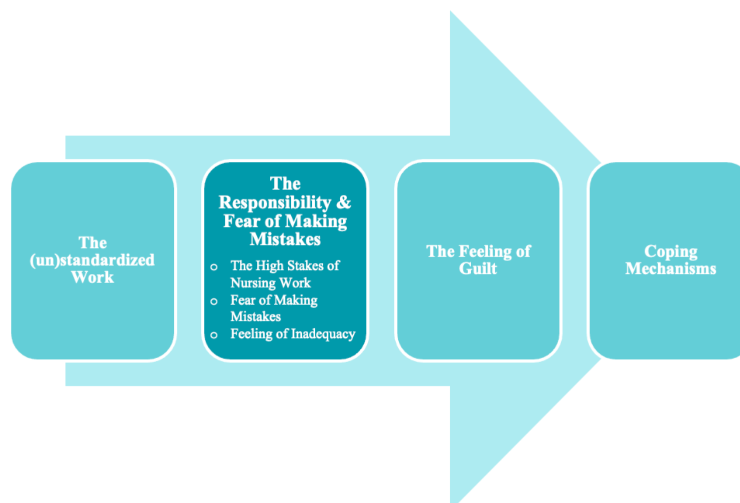

Figure 3: Overview of Analysis - The Responsibility & Fear of Making Mistakes

4.2.1 The High Stakes of Nursing Work

Throughout the interviews, it became evident that the interviewees face a great amount of responsibility. They speak about the pressure of having the responsibility for someone else's future, and in some cases, someone else's life. For pediatric nurses, having the life of children in their hands is emotional, which in its turn can complicate their work situation. Nurse C highlights the difference by mentioning that *"adult patients often want to die, they feel done, they are tired"* indicating that this absent will to live could make their possible passing easier to accept. As

mentioned, the nature of pediatric care differs from adult care, as the nurses feel like they need to adapt the care to a greater degree. This can result in them experiencing that the risks of making mistakes are more substantial, as it involves less standardized processes. Many of the nurses who have worked within the unit for a few years share the opinion that there is a staff shortage, and that there is a high employee turnover rate, which could make them feel like there is a greater responsibility on the more experienced nurses.

> *And then it was, yet again, that we have gotten so many new people here, so now I am also one of those who have been here for the longest time again, even though I don't really think I've been here for such a long time* (Nurse A).

The high turnover rate in the workforce is described as a trigger to stress. Nurse A describes how they "*once again*" are the one who are the most experienced in the pediatric unit, meaning that they become the one who gets the most difficult patients as well as a "*leading role*" (Nurse A). Hence, the high turnover rate, can result in the nurses having increased responsibility, regardless of how much experience they have gained. This is further emphasized by Nurse F:

> *I have been crying and crying… And in the toughest times, I was thinking about "how do I manage to do this?" and then I was like… " well no one else is doing it" so then you just had to do it* (Nurse F).

The level of difficulty is illustrated by Nurse F stating that they have been crying over the situation. Similarly, Nurse C described how the stressful situation made them "*anxious*" and that they had cried because of it, and Nurse A expresses that situations like these "*could make you cry and get really tired"*. Crying thus seems to be a recurring reaction to the stress that the nurses are facing due to the high workload. At the same time, Nurse F is describing that "*no one else is doing it"*, which can put the nurses in a difficult situation. Since they share a feeling of having the life of the children in their hands, they feel a need to step in, regardless of whether they have time for it or not. Nurse D concurs with this and says that "*Sometimes you don't have time to eat breakfast or lunch because you want to have enough time to do what has to be done"* (Nurse D). It could thus be understood that the pediatric nurses feel like they cannot prioritize themselves and their own

needs when at work, which could be seen as a risk for their wellbeing both in their private and professional lives.

The feeling of there not being enough help from colleagues around, as well as when nurses do not feel like they can take enough breaks to re-energize properly, could be understood as a stressor and a trigger of a feeling of uncertainty. The feeling of uncertainty can create an even more stressful situation for the nurses, creating a negative spiral.

> *There have been times when I've been thinking that "God, it would be so nice to be a cashier at ICA[1], where the worst thing that could happen is that I scanned the wrong barcode and someone gets mad at me". And not like "what if I do something wrong, like give the wrong antibiotics to this child. Worst case they die". Imagine how nice it would be to not have the responsibility for someone's life when going to work* (Nurse E).

Nurse E describes that they sometimes compare the responsibilities of their profession to those of other professions and indicate that they perceive their responsibilities to be of heavier standards. They picture the worst-case scenario, and that a child might die if the dosage of medicine is incorrect. Similarly, Nurse B expresses that "*I have the lives of these little children in my hands*", emphasizing that the responsibilities are a matter of life or death when working with pediatric care. By saying this, they are expressing the demands they experience as a nurse, both from themselves and from society.

4.2.2 Fear of Making Mistakes

It became clear during the interviews that due to the high demands, the nurses often experience genuine fear of making mistakes in their role as nurses or assistant nurses. Nurse B describes how they, as a newly graduated nurse, did not feel ready to have the responsibility connected to the nursing role: "*I did not feel ready for that role, neither in terms of knowledge nor in terms of experience"*. Having the right knowledge could thus be understood as an essential factor in feeling certain about the decisions you make. Similarly, Assistant Nurse A describes situations where

[1] ICA is one of the leading grocery store chains in Sweden.

patients with uncommon or new types of diseases are in need of care as "*scary*" due to the fact that "*you don't really have the right knowledge about it*". On the other hand, Nurse A, gives us an example of what it feels like to be more experienced, but having less experienced colleagues, and mentions a recent incident they also recall as *"scary"*; *"...if something goes wrong, will [the less experienced nurses] figure it out, if I'm in the restroom?"*. This indicates that leaving the less experienced nurses, even for a bathroom break, could leave the nurses feeling stressed and nervous as they feel responsible for what happens, even if they're not there. In other words, both having the feeling of not being knowledgeable enough, and the feeling of *others* not being knowledgeable enough could increase the feelings of uncertainty and decrease the feeling of security amongst the pediatric nurses.

> *I just cried and cried and cried for this family and for this child, who had gotten this care injury which should not really have happened, and who shouldn't have died. Everything just went wrong. It was a routine procedure where everything just went to hell, and it was just a matter of time* (Nurse A).

"*Everybody makes mistakes"* (Nurse E), and as described earlier, a small mistake could lead to severe consequences. In the quotation above, Nurse A describes a routine procedure where everything just *"went to hell"*. The strong usage of words implies the strong feelings associated with making mistakes and their consequences. Accordingly, "*making a mistake"* (Nurse C; Nurse E) or "*forgetting something"* (Assistant Nurse A) seems to be a fear that could be identified in all of the interviews in one way or another. This illustrates how the responsibility that is put on the nurses could affect them and consequently their wellbeing. They often put a large pressure on themselves, as they do not seem to associate mistakes with the role of a nurse.

4.2.3 Feeling of Inadequacy

The feeling of responsibility is further exemplified by many of the nurses in terms of not being able to let go of work when they get home at the end of the day. Nurse D says that "*you really take the work home with you, and you think about it, and ponder, a lot at home"*. All nurses except one express similar perceptions about the ability to leave the work at the hospital, and some mention having trouble sleeping by not being able to "*come to rest*" (Assistant Nurse A) or simply "*not*

being able to fall asleep" (Nurse C). Due to this, even if they do not want to, it could be understood as if the nurses work at all times. Yet they still feel like they are not doing enough, or that they are inadequate.

> *It was never really enough. It was not like you didn't work your shifts, but there was always staff missing and you were chased by the hospital regardless of the time of day, and regardless of whether or not you had worked seven shifts in a row, you always got a phone call. You were constantly chased and it was never enough, even if you took on your extra shifts. So it was never enough* (Nurse E).

In the quotation above, the nurse describes how regardless of how much they were working, they experienced it as if their work was never enough. Nurse A, B, E, and D all express that they often feel like they are inadequate in their job. Nurse D describes this by saying that "*I feel that you are never really doing enough for [the children]. You want to help them so badly, but every day you need to prioritize differently"*. The nurses also express difficulty in feeling that they are doing enough when having the patients' parents around. Nurse B explains that "*you feel like you want to split into two parts, where one part takes care of the parents, and the other takes care of the child*". It could thus be understood as if there is a need to be able to support both the patients and their parents, which can be hard to manage with the limited time and limited staff they have at the pediatric unit, leaving the nurses feeling inadequate.

To summarize, a common perception amongst the nurses is that the stakes of their work are higher in their understanding, compared to the stakes of other professionals or even other units within the hospital. This leads to the possible mistakes made by the nurses being perceived as more substantial. The heavy burden of responsibility combined with the substantial outcomes of mistakes made contributes to the fear of making mistakes, which in turn leads to them experiencing feelings of inadequacy. The pediatric nurses further describe how these high levels of responsibility, fear of making mistakes, and feelings of inadequacy result in them feeling anxious about their work and the frequency of crying because of work-related demands. All this combined thus has the means to upset their wellbeing which is important to investigate further.

4.3 The Feeling of Guilt

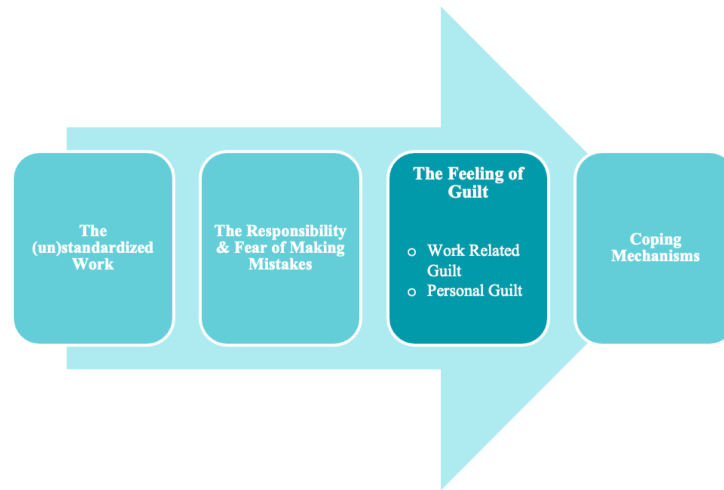

Figure 4: Overview of Analysis - The Feeling of Guilt

4.3.1 Work Related Guilt

The immense responsibility and feeling of inadequacy can result in strong feelings of guilt, which could affect the nurses' wellbeing negatively. During the interviews, it was clear that the feeling of guilt was recurrent when analyzing the nurses' perception of their everyday work.

> *I feel like I need the free time that I get. But then again I also want to help, of course, so I try to do that… But then I do it to be nice, or because I feel like I should help, not because I feel like I really want to take on an extra shift* (Nurse D).

Nurse E explains that it is "*very hard to say no*" when being called in for an extra shift, and Nurse D seems to have the same perception. They explain how they only take the extra shifts "*to be nice*". This could be understood as the nurses feeling guilty for not helping out and saying yes only to please the hospital and their colleagues.

> *We had a meeting with all the nurses where our manager had made a list of all the nurses and the number of extra shifts they had all taken on over a certain period of time. One other nurse and I hadn't taken on any extra hours, and for everyone else, they had worked a lot of extra shifts* (Nurse B).

At the same time, it can be interpreted as the nurses experiencing guilt when their hours worked are presented at meetings, and they see that they have not taken on as much work as their colleagues. Even if there are reasons for not working extra hours, such as "*working 85% is my full time*" (Nurse A), "*I only work full time for the money"* (Nurse B), and "*I shouldn't have to work more than 100%"* (Nurse C), the comparison of hours creates guilt towards each other amongst the nurses. Additionally, the pediatric nurses experience pressure, as the unit emphasizes the importance of being a "*good colleague*" (Nurse C; Nurse A; Nurse E) by answering the phone and acting collegial, and it could thus be understood as if the nurses feel guilty if they do not comply with these expectations.

> *But at the same time, when there is a lack of nurses here, and someone is sick, then we are those who have to call our colleagues, and if they don't pick up the phone, then we have to stay for another shift. I guess that's why they want us to answer the phone at all times* (Nurse C).

> *If you're the one who is calling around when someone is sick and we need extra staff, and there is no one who is picking up the phone, what should we do? Well, then I have to stay and do an extra shift, a double shift. We can't leave* (Nurse B).

When it comes to calling in people for extra shifts, which at certain times a day, nurses need to do themselves, they gain the perspective of being on the other side. The quotations above make us understand that being called in during their free time could create guilt for the nurse who is off for the day, as they know that their colleagues are in need of assistance, yet they still want to prioritize their free time for being able to recover between shifts. Furthermore, "*the majority of those who come in are rather sad*" (Nurse A), which could make the nurses calling in their colleagues feel guilty as they know that they have taken away their colleague's free time, and possibly their only time to recover between shifts. In other words, it could be interpreted as if the nurses need to balance taking care of each other and taking care of themselves, which can act as a constraint on their wellbeing.

> *…at the pediatric unit, it is like, what I don't do today I leave over to the next one. Sometimes when we haven't had time we leave tasks for the next nurse, and that is no fun* (Nurse A).

The nurses at the pediatric unit work shifts and take over from each other. Nurse A is explaining how this is not a part of the job that they enjoy by saying that it *"is no fun*". Nurse B describes how the workload becomes heavy and how unexpected occurrences arise frequently: "*it must be like that (...) you don't have more time than you have"*. This could leave the nurses not being able to finish their tasks for the day, meaning that they will have to hand them over to the nurse taking over. This could be interpreted as the nurses feeling guilty for handing over their unfinished work, as the pile of work grows every day. The nurses do not want to contribute to an even higher workload as it affects the nurses negatively and consequently their mental wellbeing.

4.3.2 Personal Guilt

The nurses did not only express how they frequently experience the feeling of guilt in their workplace. Those who have children of their own indicated on several occasions the struggle of switching between the roles of being a parent themselves and working with children. Navigating between the expectations of their families, co-workers, and patients can, therefore, act as a source of guilt.

> *You feel like you don't have enough energy to take care of it. And then you are tired as heck afterward. Because no one sleeps properly between a night and a day shift. You get really tired and then you're not a fun person at home either. No, you don't even have the energy to do something that you think is fun* (Nurse A).

> *I didn't feel sufficient as a nurse. I didn't feel sufficient as a mother, and I didn't feel sufficient as a wife. I felt really torn and constantly tired and stressed out* (Nurse E).

Having the responsibilities as a nurse can leave Nurse A feeling tired, resulting in them not living up to their own or their families' expectations of how they should be at home. The pressure of letting their family down by *"not being a fun person at home"* highlights the additional pressure

of domestic life combined with the nursing role. Nurse A describes how having these additional roles and expectations of being a nurse, mother, and wife all at the same time can make them feel guilty regarding not being fun enough at home which Nurse E supports when explaining how they have felt constantly "*torn*". Having to juggle these different roles often leaves nurses feeling guilty, not living up to their own expectations of being a good nurse or a mother. Nurse A describes how they do not want to feel guilty about leaving their co-workers with a heavier workload when not taking on an extra shift:

> *No, I don't want that either, but I don't want to feel bad for wanting to be at home with my family. I think that I already spend such little time with my child and stepchildren* (Nurse A).

However, they indicate that they struggle internally, and not feeling guilty about staying home with their children does not come easily. Therefore, it seems like they must convince themselves that the fact that they spend such limited time with their children is reason enough for staying home. This could be understood as if the nurse is feeling guilty both in their professional and private life. In the meantime, younger nurses with no children often feel pressured to take on a heavier workload than those who have children.

> *I work a lot of night shifts, partly because I'm not a morning person, but also because I think that the nurses who have children of their own want to work the day shifts* (Assistant Nurse A).

> *I don't have any children, and I don't plan on having any in another few years, but there are many who say that "I only see my children an hour per day" or something like that. But at the same time, they have chosen to work irregular hours. They could have gotten a day job instead if it affects them that much. But at the same time, I understand. It's probably really sad to see them so rarely, but the rest of us also want to do things. I guess it tends to be like that, that those who have children are the ones who stay at home the most as they need to stay home with their sick children for example* (Nurse C).

This indicates that due to the working environment and pressure from co-workers, those who are not parents are expected to step up and take on extra shifts or less convenient working hours. Furthermore, Nurse C describes how they experience that their time off is of less importance and that those who don't have children of their own also have the desire to enjoy their time off. Moreover, they describe how they feel pressured to cover for their co-workers who need to stay home with their sick children. Nurse C indicates that they do not see it as their responsibility since their co-workers chose to work within healthcare. At the same time, they sympathize with their co-workers which leads to them taking on extra shifts.

As discussed, we acknowledge that the feeling of guilt is recurring and described as a burdensome feeling that the nurses struggle to deal with. They, therefore, discussed ways in which they try to avoid the feeling of guilt in their professional life. Since the feeling of guilt arises from various sources, being their co-workers, patients, and their own family, avoiding guilt can prove to be difficult. In order to escape this difficult feeling, it could be understood as if they often decide to "*not answer*" (Nurse B) when being called in for an extra shift. "*If you don't want to, then you choose not to answer, because if you answer you will be forced to come in*" (Nurse C). The nurses are in other words avoiding the calls for extra shifts as they do not want to feel forced to do it. If they really do not want to work, then they feel like they can't say no, and if they actually do say no, they could feel extremely guilty for leaving their co-workers with a heavier workload and not living up to their own expectations of what being a good nurse and colleague entails.

To summarize, the pediatric nurses express frequently how they often find themselves feeling guilty for not living up to their own and others' expectations of what it entails to be a good colleague and thus a good nurse. This guilt can play out towards colleagues as they know the importance of having free time to be able to re-energize between shifts so that they all can continue being what is perceived to be a good nurse. The combination of different roles, having a family of your own, and working as a pediatric nurse further enhances these feelings of guilt, since they then have a multitude of external and internal expectations regarding how they ought to be to fulfill the demands involved.

4.4 Coping Mechanisms

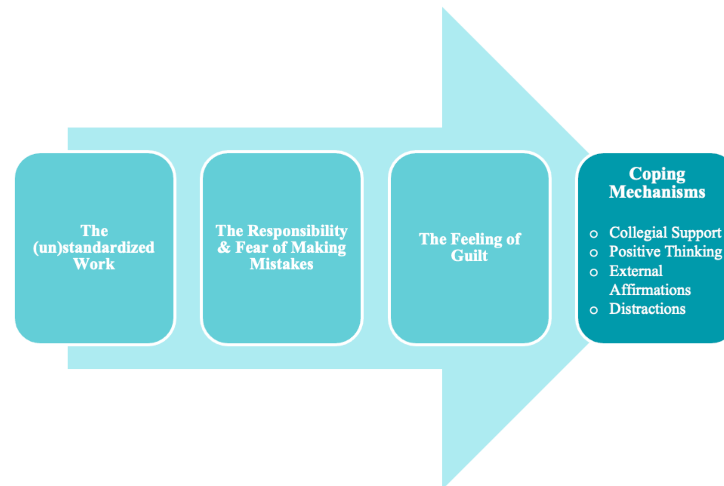

Figure 5: Overview of Analysis - Coping Mechanisms

The sections above all suggest problems that the pediatric nurses face in their everyday working situations. The problems are complex and emotional, and thus powerful. It could, however, be interpreted as if the nurses experience difficulty in managing these powerful issues due to their working situation, and it is, therefore, interesting to investigate further and gain an understanding of how the pediatric nurses cope with this.

4.4.1 Collegial Support

As discussed, different aspects of working within the pediatric unit create internal and external conflicts which affect nurses' wellbeing. Several statements from the interviewees can be interpreted as coping mechanisms, ways which help them cope with this hectic way of working.

> *It can also be nice to come back to work. Because then you are perhaps working with the same colleagues who were working with you during the difficult shift. Then you get the chance to talk about it together and such, so I think it can be a good thing. It can also act as recovery* (Assistant Nurse B).

> *When we've been in difficult work situations, we sometimes have supervision with a counselor. But we all feel like "no, we have pretty much solved everything ourselves". Like*

> *we talk a lot about it together and express our feelings so it feels good to leave it at that and continue* (Nurse A).

The positive working environment and the close relationships between the co-workers seem to act as important factors in assisting the employees to cope with difficult situations. Assistant Nurse B mentions how coming back to work can also be nice since they have the chance to process what happened with their colleagues. They go as far as stating that they see this as recovery. This is supported by Nurse A who mentioned an incident where supervision with a counselor was not necessary due to the fact that the nurses had *"pretty much solved everything"* themselves. According to the interviewees, open communication and the working environment and its culture could play an important role when coping with difficult situations at work. Being able to discuss and process their feelings with co-workers thus helps them cope with difficult situations. This is particularly interesting since the pediatric nurses describe how their work environment acts as a constraint on their wellbeing but at the same time, suggest that it can act as a coping mechanism.

4.4.2 Positive Thinking

During the interviews, we acknowledged that the pediatric nurses often seem to cope with their situation by convincing themselves that it is better than what they actually perceive it to be.

> *You become, yeah, you become pretty tired of it. It has been very tiring. But sure, perhaps soon it will lighten up a bit* (Nurse A).

The pediatric unit has been under severe stress recently due to a rise in infections, which has taken its toll on Nurse A who describes it as very tiring. In order to cope so that they can continue working, it seems like they try to convince themselves that there are brighter days ahead which will make the hard work worth it, which can help them pull through difficult situations. However, there is a limit to how long they can continue on this path and the question remains whether this way of coping is sustainable in the long run.

> *I think I often try to when I find things difficult and I feel like I will take the worries home with me. Then I try to flip it around to see the positive things I actually have in my life.*

> *What I have to be thankful for and I really believe I can turn those difficult times around by doing so* (Nurse E).

> *Some days I get angry because of something that doesn't really matter. Then I think of the parents I've met that don't know if their child will survive until tomorrow. Sometimes you just need that perspective. But sometimes you also have to be able to feel like, it's ok that I am really angry and really sad. It's a small thing compared to having a child with cancer, but today I feel sad and I'm angry and I don't feel like a good mom, and that's ok. It took a good amount of time to get there though. I think it's a process that takes some time* (Nurse E).

Nurse E on the other hand mentioned how the perspective of having a healthy family can help them cope with difficult situations at work. This insight brought by having healthy children of their own helps them cope with working with sick children by flipping these situations around and seeing the positive aspects of their own life. This positive way of thinking could be understood as helpful by shifting their perspective and thus, coping with this difficult work environment. Since working with severely ill children can be emotionally draining and hard to cope with, it seems like Nurse E is in need of this positive assurance to feel better about their surroundings. It's almost as if the negative and difficult situations become easier since they have the positive aspects of their own life to assure themselves with. When feeling angry they tend to belittle their own emotions and think of parents that are unsure if their child will survive, stating that they sometimes need this perspective in order to avoid difficult feelings of anger or sadness. However, it could be interpreted that they struggle with this way of coping since they must convince themselves to be thankful for the health of their own children, even when feeling angry, sad, and like they are a bad mother. When dealing with these thoughts they tend to convince themselves that it is alright for them to feel that way. They describe it as a process that takes time since they find it difficult to allow themselves to experience and process these natural feelings whilst working in such difficult situations.

4.4.3 External Affirmations

The empirical material further suggests that external validation from patients and their families can also act as an important factor in validating the interviewees' self-worth. This, in turn, could create a manageable work environment for them to navigate within. Parents can contribute with practical help, as described by Nurse A who explains that parents often feed the children and change their diapers. Nurse D mentions that "*most of the time they are very helpful"* and Nurse E describes this as a "*positive*" thing. Assistant Nurse A further explains how parents usually are "*easy to cooperate with*". By being present and taking care of their children, parents often leave room for the nurses to focus on other pressing tasks.

> *…or you could get a nice drawing from the children, and where the parents have written something like "you have taken such good care of us when we've been here", and small things like that. It makes a big difference* (Nurse E).

Children and their families show appreciation for the nurses by giving them small symbols of love, such as a nice drawing made by a child. The fact that the parents also participate in this kind of symbol of appreciation indicates that it is not only the child who is being taken care of, but the whole family. This in turn, could be understood as the nurses feeling that they have an impact on their lives and thus fulfill the internal and external expectations of being a pediatric nurse. Other symbols of appreciation from the families include hugs, which Nurse B mentioned on several occasions: "*they are amazing, they are fantastic, they get happy when you come, and they hug you and show so much appreciation"* (Nurse B). The strong relationships that are built with the children and their families could thus be seen as a source of energy for the nurses, providing them with external validation which has the means to enhance their self-worth.

4.4.4 Distractions

Other ways of coping involve being able to let go of work easily or even shut it out. Nurse D describes how learning to let go of work easily is a skill that those who have worked at the unit for a longer period of time obtain.

> *I think it also has to do with the fact that you learn how to shut it out. We who have worked here for a long time have learned how to let go of work easily. But when you're new I believe you think more about work and bring work home with you more often and in a different way* (Nurse D).

Letting go of work or shutting it out is mentioned as something they do in order to be able to recover and rest at home. This could be understood as if the balance between work and domestic life can often be imbalanced and that work is hard to let go of when at home. Hence, they describe how being able to rest and let go of their worries becomes a skill or a coping method that requires practice.

> *Some nights you walk around at home and think "what the heck are we supposed to do, can we do this?". Then I tell myself "yeah but you're at home now, you should be cooking bolognese, stop it"* (Nurse A).

> *But then when I get home, and especially during the weeks when I have my children staying with me, worries regarding work disappear easily. Since I have to focus on something else* (Nurse B).

Nurse A describes how the responsibilities at work can be hard to let go of when at home. Despite being at home with their family they are left wondering what to do in a work situation. The responsibilities of having a family to take care of could be understood as a driver to shift between their personal and professional roles, even though it can be hard to let go of. By convincing themselves to *"stop it"* and take care of other responsibilities such as cooking dinner for their family, the nurses are more able to distract themselves at least for a short period of time. Having children themselves can thus be understood as a coping mechanism for the nurses, who are either forced to or force themselves to shift their focus and focus on their own children, at home. Similarly, Nurse B describes how it is easier to let go of work-related worries when they spend time with their children as they *"have to"* focus on something else. It could be understood as the nurses are coping by constantly focusing on either their patients or their families. However, little of the empirical material gathered indicates that the nurses focus on themselves.

To conclude, with the previous sections in mind, it is clear that the pediatric nurses are in need of means to manage their difficult working situation in order to protect themselves and their self-esteem. Accordingly, the empirical material suggests that the pediatric nurses find many ways to cope, such as through the collegial support at work, convincing themselves to think positively, getting external affirmations from patients and their families, and by distracting themselves when not at work to escape the feeling of having to work at all times. However, as mentioned, the empirical material shows few indications of the nurses putting any focus on themselves, which could be destructive to their wellbeing.

5 Discussion

In this chapter, the analyzed empirical findings of the study will be positioned in a broader theoretical context. Initially, we will present the pediatric nurses' working situation as complex due to the emotional aspects. Next, a discussion about how this can undermine professionalism and thus trigger identity work will be conducted. This is followed by an evaluation of identity work within pediatric nursing. Finally, a paradox of the pediatric nurses' working situation will be presented.

Figure 6: Overview of Discussion

5.1 The Complex Working Situation

5.1.1 The Working Situation

As presented in our empirical analysis, the pediatric nurses interviewed described their working environment in detail. At the same time, their experiences of their own and society's expectations of them as nurses were described, and could therefore provide us with some understanding of how they perceive the expectations involved. It could be argued that the situation in which the pediatric nurses work is different from other types of healthcare work, due to the emotional aspects of the work situation. Professional work is often standardized (Abbott, 1988; Timmermans & Berg, 2003), and the nurses clearly describe how working with children differs a lot from working with adult patients, as they need to individually adjust for every patient they have. Moreover, the pediatric unit of the hospital takes care of children with a variety of needs and illnesses, whereas other units specialize in specific areas of care. Being a pediatric nurse is thus different from being a healthcare worker at other units. Their perception of this becomes evident as the nurses describe that healthcare workers from other units are not familiar with their way of working, highlighting the level of professionalism within the profession as described by Andersen and Pedersen (2012). We could therefore identify that the work of a pediatric nurse is not standardized, despite its requirements of professionalism. Furthermore, professionals acquire their knowledge initially with

formal education, as described by Ghadirian, Salsali, and Cheraghi (2014), and the nurses could therefore feel the need to rely on their education when at work. However, as seen in the empirical material, the nurses often perceive the unstandardized work to be an uncertainty as they question their level of knowledge. Additionally, the workload is high, resulting in the nurses feeling helpless and anxious as they feel like they cannot live up to their role as pediatric nurses due to lack of time. The nurses often put extremely high expectations on themselves in order to adhere to their professional role and describe this as troublesome as they even fantasize about working as a cashier at a grocery store instead of being a pediatric nurse.

5.1.2 The Emotional Aspects

It could be understood from the empirical material that the emotional aspects of the work could complicate the work of a nurse. The empirical material suggests that one of these aspects is the continuous presence of the parents which seems to put additional pressure on the nurses. Firstly, as stated by the nurses, the parents do a lot of the taking care of their children that nurses otherwise would have to do. Therefore, the pediatric nurses' work does not merely involve the stereotypical nurse job description, and they thus perceive their work to be of higher standards. Furthermore, it could be understood from the empirical material that the pediatric nurses feel the need of being a nurse to both the patient, but also their parents, and are thus required to engage beyond the descriptions of a nurse. The parents expect the nurses to act both professionally and be empathic, as described by Cain (2012) and Mann (2004) and are thus expected to show genuine emotions and perform deep acting at the same time (Hochschild, 1983). The pediatric nurses thus convey the impression of them being expected to both act within the frames of the role description, but also beyond. Similarly, the management of the pediatric unit also has expectations of the pediatric nurses and guilt arises amongst the nurses by the management's emphasis on being a good colleague. By doing this, the management ascribes further demands on the professional role of a pediatric nurse, which complicates the situation as the role description goes beyond what was expected.

5.1.3 The Implications of Domestic Life

Furthermore, the empirical material implies that aspects, such as one's home, which one would expect to be a relief from the hectic work situation, actually seem to worsen it. The nurses describe

that the work is often brought home due to the emotional nature of the profession, as described by Sanz-Vergel et al. (2012). They consequently express having trouble sleeping and having trouble letting go of the worries connected to their job. Moreover, it could be understood that the nurses are expected to be available at all times and be prepared to leave their homes for extra shifts. We, therefore, see that by bringing the work home, it becomes more complicated for the pediatric nurses to navigate between their professional role and their personal role, since shifting between different roles can be more difficult (Sanz-Vergel et al., 2012). However, it could be understood as if the nurses have expectations of themselves as private people as well, like being a good family member, and it becomes difficult for them to balance their multiple identities. If the nurses work too much, they feel like they let down their family, and if they spend too much time with their family, they feel like they let down their colleagues. This thus results in the nurses becoming more vulnerable to the stressors and strains of multiple roles (Wharton & Erickson, 1993), which further complicates the situation in which the pediatric nurses are working.

5.2 Undermining of the Self-Image

5.2.1 Undermining the Professionalism

Keeping in mind the above, we argue that the empirical material suggests that the emotional aspects of the pediatric nurses' working situation risk undermining the professional identity as a pediatric nurse. Similar to that of Sveningsson & Alvesson (2003) the unstandardized work, constant interruptions that the pediatric nurses are experiencing in their work situation, and the questioning of their own knowledge, could be understood to provide a great amount of uncertainty to the work situations. Consequently, this uncertainty could result in negative effects on the pediatric nurses' self-esteem, and thus their professionalism. At the same time, the expectations and demands they have on themselves and societal expectations seem to depend on the context they are in, concurring with Sveningsson, Gjerde, and Alvesson (2021) and Alvesson and Billing (2011). As discussed, the nurses could thus both be required to work within the frames of what a nurse can do, but also beyond. The role of a pediatric nurse is thus seemingly complicated as these demands could be internalized by the nurses, making them feel inadequate and guilty if they cannot meet their own and society's expectations. This guilt can create further uncertainty as it affects the self-esteem of the nurses, thus supporting Lutwak, Ferrari & Cheek's (1998) findings regarding how guilt can affect one's self-esteem in a negative sense, which could lead to them questioning

their identity as a professional nurse. With all the above in mind, we would like to argue that the professional identity of a pediatric nurse is not stable, as opposed to what Abbot (1998) and Chreim, and Williams and Hinings (2007) claim, since the nurses' perception of the professional identity continuously changes, as they need to balance the external expectations with their role description.

In accordance with Sveningsson and Alvesson (2016) and Eilam & Shamir (2005), we have witnessed how input from the social environment could threaten the self-concept. The emotional aspects of working as a pediatric nurse, such as the guilt, the uncertainties, the feeling of inadequacy, and conflicts can thus be seen as aspects of the work that are undermining the professional identity, making it difficult to maintain a coherent role. The pediatric nurses' perception of their working situation can thus be equated to research regarding identities within healthcare, where they need to integrate different and sometimes conflicting identities (Cain, Frazer & Kilaberia, 2018). This becomes evident in the empirical presentation as the pediatric nurses clearly engage beyond what their professional role requires. They seem to invest both time and emotions which could result in them establishing deeper relationships at the workplace, but also deeper conflicts within themselves. This in turn could make it more difficult for the nurses to identify with the professional identity of a nurse, and thus question themselves and their work. Moreover, low self-esteem and a high level of uncertainty, are not abilities usually connected to professionalism or a strong identity. We could therefore argue that the pediatric nurses of this study lack a strong identity, which affects their abilities to act professionally.

5.2.2 Trigger of Identity Work

In accordance with Hochschild (1983) we argue that pediatric nurses make use of different coping mechanisms to relieve themselves when the emotional pressures threaten their professional identity. As presented in the analysis chapter, this is done both through external validation and through internal coping mechanisms. External validations, such as verbal affirmation from parents, and small gifts from patients could improve the nurses' self-esteem, as their work and performance are explicitly confirmed. These validations are seen to be remarkably meaningful for the nurses and are thus taken to heart to a greater extent, leaving a big impact even though being perceived as small gestures. This could in other words be understood as means of contributing to the nurses'

self-esteem, alleviating the feeling of uncertainty, and thus contributing to a more coherent professional role. Furthermore, the pediatric nurses seem to reinforce their self-view and self-esteem by using coping mechanisms, and it could thus be interpreted as the nurses are either forced to or feel a strong need to engage in intensive identity work, as described by Sveningsson and Alvesson (2016). Two of Sveningsson and Alvesson's (2016) forms of managerial identity work can also be found in the empirical findings of our study, namely identity wrestling and identity crashing. Identity wrestling is present in the pediatric nurses' perceptions of their work situation, as they could experience many highs and lows, and the low self-esteem and high uncertainty that is created due to the emotional aspects of the work risk undermining the professional role. The nature of the job as a pediatric nurse could thus be understood as a cause for identity wrestling, but there is also empirical material suggesting that identity crashing is present. Some pediatric nurses find it very difficult to handle the emotional aspects of the work, without letting it undermine their professional role, and ultimately decide to change their type of employment, need to go on sick leave, or even quit their job. As Sveningsson and Alvesson (2016) describe, if identity work does not improve the nurses' situation, this eventually results in identity crashing, where an exit is oftentimes the only way to recover.

One of the coping mechanisms identified in the empirical presentation is how the pediatric nurses convince themselves that their situation is not as bad as others, that the workday will be fine even though they really have a different feeling, and think about how it will get better as you learn how to let go of work. This is similar to what Sveningsson and Larsson (2006) call hopes for the future, meaning that an imaginative and attractive self-image is created, which in this case could strengthen the nurses' self-image as they to some extent let go of the factors influencing their identity negatively. Moreover, the working situation could be described as therapeutic, as the nurses find themselves coping with difficult and undermining situations by ventilating with their colleagues, and we thus agree with Bolton and Boyd (2003) in that emotions within a professional work allows emotional exchange and support amongst colleagues. The emotional aspects of the work of a pediatric nurse thus act as a constraint to their ability to be professional but simultaneously it seems to be the only solution to the undermined role identity. However, the identity work concepts of identity wrestling, crashing and hopes for the future are all referring to

the identity work of managers. Even if these concepts can be seen in the empirical material to some extent, we see a need of creating a framework of identity work amongst pediatric nurses.

5.3 Identity Work of Pediatric Nurses

Our empirical findings suggest ways in which the pediatric nurses' working environment has the means to upset their identities, and how they cope with these identity struggles. The identity outcomes and identity work presented by Sveningsson and Alvesson (2016) are presented in a managerial context and consequently are not always applicable in the pediatric nursing context and thus, do not reflect the reality of pediatric nurses.

Building upon Sveningsson and Alvesson's (2016) criteria of identity outcomes and identity work, as well as Sveningsson and Larsson's (2006) hopes for the future, we suggest five terms that describe how identity struggles and identity work play out in the pediatric nursing context.
We present the states of *identity infection* and *identity emergency*, and the forms of identity work: *identity bandage, identity medication,* and *identity defibrillation*. The state of *identity infection* is when the pediatric nurse's identity is "infected" due to experiencing an identity threat of some sort. Although Sveningsson and Alvesson (2016) suggest four different identity outcomes which involve low to medium intensive conflicts, we argue that they can all be combined and presented as an *identity infection* within the context of pediatric nursing. The intensity of the *identity infection* can thus differ between situations, contexts, and individuals, just as physical infections do, therefore we see no need for creating separate terms based on the intensity of the identity work. This term is however perhaps most similar to identity wrestling, which is characterized by contradictory demands, some fragmentation, identity traps, and medium intensive struggles where there is a high willingness to compromise (Sveningsson & Alvesson, 2016). This *identity infection* can then either be repaired by putting on an *identity bandage* or taking *identity medication* depending on the severity of the *identity infection.* An *identity bandage* then refers to short-term solutions when the pediatric nurses put a bandage on their struggles, like expressing their feelings and seeking support, as described by Bolton and Boyd (2003). The *identity medication,* however, refers to long-term identity work that the pediatric nurses engage in over a longer period of time. Examples of this could be learning how to shift their focus or simply shutting their worries out, something they learn how to do to minimize the negative consequences of their *identity infection.*

These forms of identity work present when involved in low to medium intensive conflicts, are thus similar to the fantasies mentioned by Sveningsson and Larsson (2006) but further elaborated on and put in a pediatric nursing context. Since the forms of identity work can differ between individuals, we argue that dividing them up into short-term solutions *(identity bandage)* and long-term solutions *(identity medicine)* provides sufficient distinction. When pediatric nurses experience more severe identity struggles, their *identity infection* becomes an *identity emergency* instead, a dramatic threat or struggle with their identity. The term *identity emergency* is similar to the state of identity crash which is described as a strong identity trap with high-intensive struggles and disintegration (Sveningsson & Alvesson, 2016). When experiencing an *identity emergency,* we argue that a drastic solution such as *identity defibrillation* is the only way in which they can repair their identities, requiring substantial actions such as decreasing their working hours, switching positions within the unit, or even quitting. This further correlates with how Sveningsson and Alvesson (2016) describe an identity crash where an exit of some sort is often the only way out, but further elaborated on within the pediatric nursing context. We therefore further suggest that this exit of some sort (Sveningsson & Alvesson, 2016) is a form of identity work required to recover from an *identity emergency,* which we call *identity defibrillation*. The distinction between these two types of identity struggles and the three ways in which they repair their identity are illustrated in Figure 7.

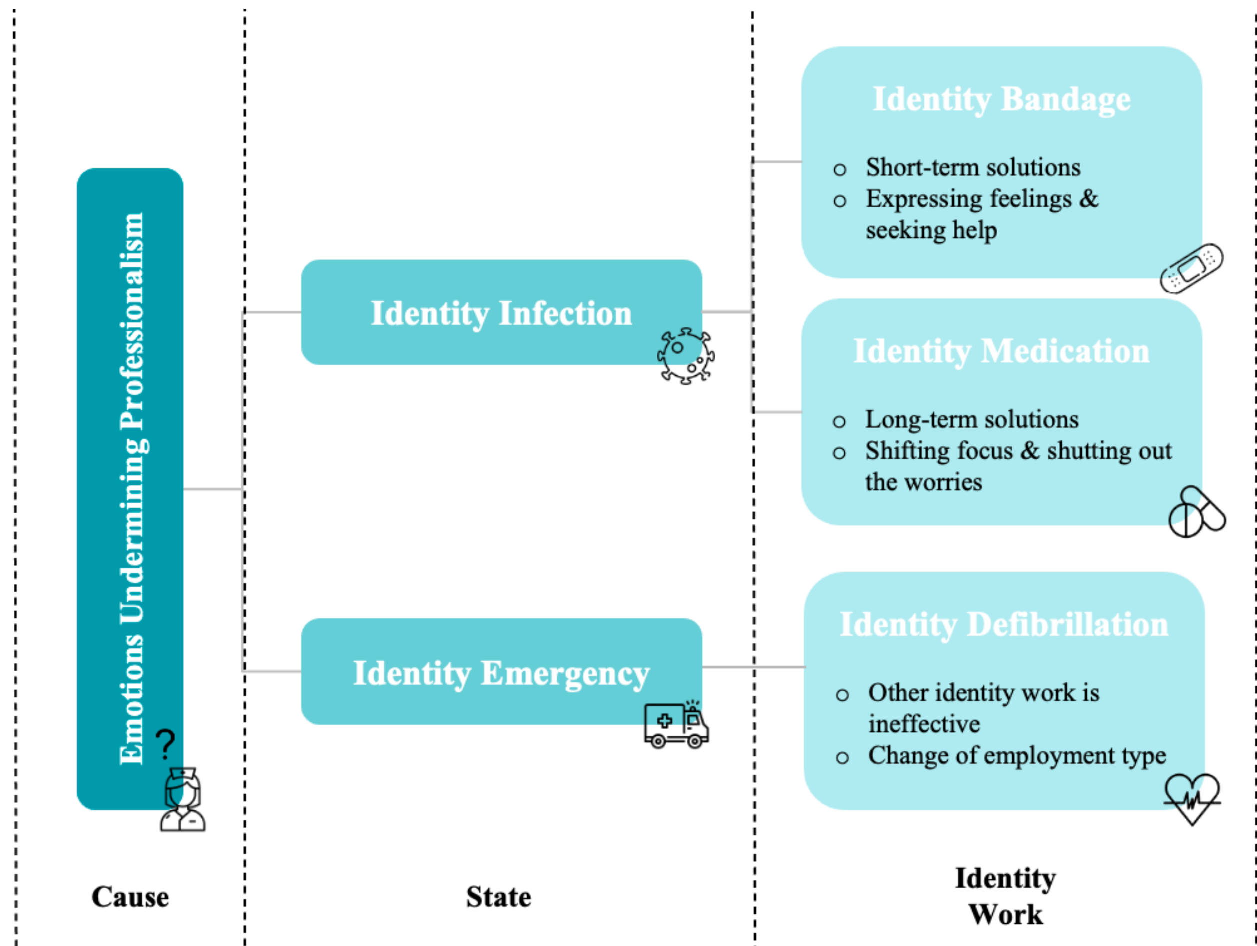

Figure 7: The Nursing Identity

5.4 The Nursing Paradox

As presented in the analysis chapter and further discussed above, pediatric nurses often go above and beyond their own and society's expectations of their professional role. They establish and engage in personal relationships beyond the scope of their professional job description at the same time as they experience internal and external pressures from themselves, patients, colleagues, and society. These struggles produce difficult feelings such as guilt, the feeling of inadequacy, and fear of making mistakes. Consequently, undermining their personal and professional identities which oftentimes results in *identity infection* or *identity emergency.* Having described in detail how these struggles play out in the context of pediatric nursing, we found it particularly interesting that the same setting which causes them identity struggles and distress, also helps them cope. Previous research has mentioned how emotional labor allows support amongst colleagues (Bolton and

Boyd, 2003). However, we found no existing literature regarding how this paradox within the workplace plays out. Therefore, we have the opportunity to provide empirical material explaining how their working environment creates *identity infections* but at the same time, provides support from colleagues as an *identity bandage*, which consequently, helps them reestablish their professional identities. We call this phenomenon the *nursing paradox*: their work environment causes *identity infections* that are reestablished within the same setting.

6 Conclusion

The following chapter will conclude the major findings presented in our thesis. Building upon our discussion, we present our key findings and state our practical and theoretical implications. By doing so, we hope our research will provide an understanding of how pediatric nurses perceive and cope with their working situation and how this consequently affects their wellbeing. Finally, we discuss the limitations of the study and provide suggestions for future research.

6.1 Key Findings

The purpose of this research paper was to examine how pediatric nurses perceive and cope with their working situation, making use of our research question "*How do pediatric nurses perceive and cope with their working situation?"*. Our findings provide a deeper understanding of how the working situation of pediatric nurses appears on an individual level and how they perceive and cope with the external and internal pressures involved in their work. Not only do we provide qualitative empirical findings regarding how this plays out, but we further analyze, and present theoretical concepts built upon the pediatric nurses' communicated experiences. Through our analysis, we recognized recurring themes regarding how pediatric nurses perceive their working situation: (1) the complex working situation, (2) high responsibility, and (3) feelings of guilt. Along with the ways in which they cope: (1) collegial support, (2), positive thinking, (3) external affirmation, and (4) distractions. The unstandardized way of working within the pediatric unit is described as a substantial constraint on the nurses' wellbeing due to the variation, uncertainty, fragmentation, and emotional demands involved in their work. Furthermore, the great responsibility and high stakes perceived, contribute to the anxiety experienced, a greater fear of making mistakes, and thus, feelings of inadequacy when not living up to their own or society's expectations. Finally, we found the feeling of guilt to be recurrent in their descriptions of their working environment, not only on a professional level but also affecting their private lives. All these difficult feelings combined were detected as influential factors to the nurses' perception, harming their self-image, upsetting their identities, and thus triggering identity work which in turn affects their wellbeing. Based on our findings, we have developed and presented the concepts of the *nursing paradox* along with the criteria for identity work of pediatric nurses.

6.2 Practical & Theoretical Implications

6.2.1 Practical Implications

Our research aim was to investigate how pediatric nurses perceive and cope with their working situation and consequently, does not provide solutions to how this can be improved. As discussed, we suggest that pediatric nursing work involves a *nursing paradox,* where the pediatric nurses experience threats to their identity, self-esteem, and certainty, triggering identity struggles which are then reestablished within the same setting. We, therefore, hope and believe that these findings can provide medical institutions with valuable understanding regarding how the pediatric working environment affects pediatric nurses' wellbeing. Our findings provide some depth and understanding of their working situation and we genuinely hope that this can provide insight and thus help in developing an improved working environment. Hopefully, these understandings can improve the pediatric nursing role which has the means to improve the current situation which is characterized by high sick leave rates and lack of personnel.

6.2.2 Theoretical Implications

As presented in the discussion, through our research we found aspects that both correlate with and contrast the findings of previous research regarding the contrasting expectations involved in nursing work, such as the emotionality and professionality. The empirical material concurs with the common understanding regarding the professionality involved in nursing work (Anderson & Pedersen, 2012; Ghadirian, Salsali & Cheragi, 2014) however our findings suggest that pediatric nursing work is not as standardized and stable as professional work is often described to be (Abbott, 1988; Chreim, Williams & Hinings, 2007; Timmermans & Berg, 2003). Due to the emotionality of the work along with the multitude of contrasting expectations (Cain, 2012; Mann, 2004). The results further support the difficulty of differentiating between professional and personal life, concurring with the theories presented regarding emotional work and emotional labor (Bolton & Boyd, 2003; Hochschild, 1983; Sanz-Vergel et al, 2012; Wharton & Erikson, 1993). Furthermore, our findings highlight and give a deeper understanding of the variability and uncertainty of pediatric nursing (Alvesson, 2016; Eilam & Shamir, 2005; Sveningsson & Alvesson, 2003; Sveningsson, Gjerde & Alvesson, 2021). The need for integrating differing and conflicting identities (Carin, Frazer & Kilaberia, 2018) was further detected along with the need

for engaging in intense identity work (Sveningsson & Alvesson, 2016). We would however like to argue that we provide further empirical understanding regarding how these expectations take place within pediatric nurses' work environment and thus, trigger identity work and diminish their wellbeing. We, therefore, contribute with empirical and theoretical understanding applicable to nursing work and first and foremost, pediatric nursing work. We further argue that our main theoretical implication involves the nursing identity criteria presented in chapter 5.3. The criteria were developed by building upon Sveningsson and Alvesson's (2016) theory regarding identity outcomes in identity work, which they presented in a managerial context, and Sveningsson & Larsson's (2006) description of fantasies and hopes for the future. As presented, the nursing identity criteria involve two states which trigger identity work: *identity infection* and *identity emergency*, the latter being of a more serious degree. The terms *identity medicine* and *identity bandage* are thus ways in which nurses reestablish their identity, the latter involving short-term solutions as opposed to *identity medicine* which is done regularly over time, in order to maintain a rather stable identity. When these types of identity work do not work out, we argue that the nurses experience an *identity emergency* in which *identity defibrillation* acts as the only way out, requiring drastic measures to maintain a relatively coherent identity. To summarize, we believe our research contributes valuable empirical material, confirming how pediatric nurses perceive and cope with their working situation, and thus providing depth with the empirical qualitative material presented along with the theoretical concepts included in the nursing identity framework and the *nursing paradox*.

6.3 Limitations & Future Research

6.3.1 Limitations

In light of the key findings, practical implications, and theoretical implications discussed, we find it important to address the limitations present in our research. First, the social constructionist nature of the research results in ambiguity in the sense that it involves our interpretation of the pediatric nurse's perception of reality, and thus our backgrounds and values have the means to affect the analysis. Secondly, the pediatric nurses' perceptions can be influenced by several variables such as social class, age, and sex and are thus based on subjective experiences. As discussed in chapter 3.4 the interviews conducted only involved female interviewees, which possibly is due to the fact that the majority of the working force is female. At the same time, this also makes the sample

reflect reality, consequently, the male perspective is however still lacking in this study. Additionally, the interviews conducted involved two assistant nurses as opposed to six registered nurses, thus not representing the population within the unit accurately as the working force consists of an approximately equal division of nurses and assistant nurses. Furthermore, the research took place within one specific pediatric unit and does therefore not necessarily represent the situation at other pediatric units. It can thus provide some understanding and image of how pediatric units may look like, but is not necessarily applicable to other pediatric units. Finally, we chose not to focus on the effects of which the pandemic of COVID-19 had on the pediatric nurses' perceptions and experiences. For this reason, we could not control for the effects the virus had on their perception. We thus find the need to highlight the fact that even though the crisis took place shortly before the interviews were conducted, difficulties within the healthcare industry were present long before the pandemic of COVID-19 (Smith et al., 2021).

6.3.2 Future Research

As discussed, we see a clear need to investigate how pediatric nurses perceive and cope with their working situations and thus, how it affects their wellbeing. Consequently, we argue that this field of research is relatively untapped and would thus like to provide suggestions for further research. Considering what has been discussed in previous chapters, we detect a need for further qualitative and empirical research investigating how pediatric nurses perceive and cope with their working situation within different organizations, to examine if our findings are applicable to other medical organizations. Our research was conducted in a relatively small pediatric unit, and it would therefore be particularly interesting to research if and how the situation differs from our findings within larger pediatric units. Furthermore, we argue that it would be relevant to research further how these identity struggles and identity work affects their mental wellbeing, as it is of high relevance due to the amount of research highlighting the depletion of nurses' wellbeing (Erikson & Davies, 2017; Försäkringskassan, 2016; Hjorth, 2022; Lidwall & Abrahamsson, 2022; Smith et al., 2021). Finally, and perhaps of most importance, we detect a need to research further how these negative outcomes can be minimized, overcome, or even prevented within pediatric units. The aim of our research was to understand how pediatric nurses perceive and cope with their working situation and our research outcomes have thus further intensified the

need we acknowledge for suggestions of preventative measures to hinder or improve the negative impacts of their working situation.

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Appendix A

Original interview guide in Swedish

1. **Börja spela in**
2. **Introduktion**
    a. Vi studerar på Ekonomihögskolan i Lund, och tar masterprogrammet i Managing People, Knowledge & Change. Det är en utbildning inom organisation och ledarskap. Vi skriver nu vår magisteruppsats och vi är båda intresserade av mental hälsa och ohälsa då detta är något som vi båda två har erfarenhet av. Vi är därmed fullt medvetna om att det ämnet kan uppfattas som jobbigt och väldigt personligt, och vill därför vara noga med att säga att om du upplever obehag eller liknande under tiden av intervjun, säg bara till! Vi utlovar självklart anonymitet och kommer därför inte nämna varken ditt namn eller vilket sjukhus det rör sig om i uppsatsen. Intervjun kommer inte ta mer än en timme, och vi kommer ställa frågor utifrån några olika fråge teman. Vi använder oss av ett socialkonstruktionistiskt synsätt vilket innebär att vi kommer göra tolkningar av dina upplevelser och ber dig därför att berätta fritt om dina tankar och erfarenheter!
3. **Bakgrundsinformation**
    a. Berätta lite om dig själv, vem är du och vad gör du?
    b. Hur många timmar jobbar du i veckan? (anställd heltid/deltid)
        i. Vad tycker du om det, passar det dig?
    c. Hur gammal är du?
        i. Hur länge har du jobbat på avdelningen?
    d. Kan du säga något om hur och när du började intressera dig för jobb inom vården?
    e. Hur ser en vanlig dag på jobbet ut för dig?
4. **Arbetsmiljö**
    a. Beskriv arbetsmiljön på barnavdelningen
    b. Hur upplever du att relationen till dina kollegor är?
    c. Upplever du att hur du blir påverkad skiljer sig beroende på vilken avdelning du befinner dig på?

   d. Hur är det att ha barn som patienter?
   e. Styrande: om du vill ge organisationen råd, vilket skulle det vara?

5. **Yrket som sjuksköterska**
   a. Vad innebär det att vara sjuksköterska på barnavdelningen för dig?
   b. Vad är utmanande i tjänsten?
   c. Vad innebär ditt uppdrag formellt och informellt?
   d. Berätta om när det är som jobbigast
      i. Berätta om särskilda situationer - exempel
   e. Hur är det att skilja på jobbet och privatlivet?
   f. Vad är givande för dig i jobbet som sjuksköterska?
   g. Upplever du att du får tid att återhämta dig?
6. **Psykosocial hälsa**
   a. Vilken uppfattning har barnavdelning på psykisk ohälsa (almännt/anställda)
   b. Vad har du för personliga tankar om psykosocial hälsa?
   c. Har du någonsin stött dig på psykisk ohälsa?
      i. tror du att det påverkar hur du ser på det?
   d. Känner du att du kan få stöd?
      i. vart vänder du dig för stöd?
   e. Har du någonsin ångrat ditt karriärval?
7. **Frågor på slutet**
   a. Vad tycker du att vi borde ha frågat om men vi inte gjorde?
   b. Om vi ska verkligen förstå den rollen som du har, vilken fråga borde vi ställa?

Appendix B

Translated interview guide, in English

1. **Start recording**
2. **Introduction**
    a. We are currently studying the masters programme Managing People, Knowledge & Change at Lund University. Our studies involve organizational and leadership related matters. We are now writing our master thesis and are both interested in mental wellbeing and psykisk ohälsa (eng: "psychological unhealth") since we both have personal experience of these matters. We therefore fully understand that these topics can be difficult to discuss and are very personal, therefore we want to be clear that if you feel uncomfortable or experience similar feelings, let us know! Of course we promise anonymity and will therefore not mention your name at any point nor which hospital the research was conducted within. The interview should take no longer than one hour, and we will ask questions based on a few different themes. We make use of a social constructionist perspective which involves us interpreting your perceptions and therefore we ask you to communicate your thoughts and experiences freely!
3. **Background information**
    a. Tell us a little bit about yourself, who are you and what do you do?
    b. How many hours do you work per week? (Working full time/part time)
        i. What do you think about that, does it suit you?
    c. How old are you?
        i. For how long have you worked at the pediatric unit?
    d. Could you describe how and when you started to gain interest in working within healthcare?
    e. How does a normal day at work look like for you?
4. **Working environment**
    a. Describe the working environment at the pediatric unit
    b. How do you perceive your relationships with colleagues to be?
    c. Do you experience any difference in how your working situation affects you based on the unit you are working within?

d. How is it to have child patients?
e. Leading: if you could give the organization advice, which advice would it be?

5. The pediatric nurse profession

a. What does being a pediatric nurse entail for you?
b. Which aspects of your work are challenging?
c. What do your job assignments entail, formally and informally?
d. Tell us about how it is when it is most difficult
    i. Tell us about specific situations - examples
e. How do you differentiate between your professional and private life?
f. Which aspects of nursing work are rewarding?
g. Do you feel like you get time to recover?

6. Psychological health

a. Which perception does the pediatric unit have on psykisk ohälsa (eng: psychological unhealth) (generally/employees)
b. What are your personal thoughts regarding mental health?
c. Have you ever experienced psykisk ohälsa (eng: psychological unhealth)?
    i. Do you think it affects your view on the matter?
d. Do you feel like you can seek support?
    i. Where do you turn to for support?
f. Have you ever regretted your career choice?

7. Wrap up questions

a. What do you feel like we should have asked you about but did not?
b. Which question should we ask, if we were to really understand your professional role?