Understanding Nursing Resilience During the COVID-19 Pandemic Through Narrative Inquiry and Art. A Feminist Exploration in Educational Research

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Abstract

The resilience and retention of nurses is a complex and urgently compelling phenomenon in the global context, made even more critical given the challenges of the COVID-19 pandemic. Qualitative research on nursing resilience is an under-researched topic, particularly within nurses' personal stories of resilience. This study incorporated narrative inquiry and arts-based research seen through the lens of a feminist theoretical framework. It explored the stories of nursing resilience told from the perspective of four public health nurses during the COVID-19 pandemic. In the spirit of Connelly and Clandinin (1990), the focus of this narrative inquiry is not only on the individual's experience but also on the social, cultural, and institutional narratives within each individual's experiences that are derived, shaped, expressed, and enacted. The stories of nursing resilience were shared in group discussions, one-on-one interviews focused on conversations and artistic collages with artist statements. This research wove together stories of nursing resilience and elucidated the impact of emotional labour, camaraderie, mentorship, and self-care on the developmental process of resilience. The positive effects of feeling valued within the power structure in nursing are highlighted. Higher education curricula do introduce the concept of nursing resilience, but the focus in nursing education programs is on medical and technical knowledge. There are many factors which are influencing the need for nurses to be more resilient in the workplace, nursing students will need to learn much more about this subject and how it can impact them both personally and professionally. Implications for further research on mentorship, the group effect of research and the therapeutic nature of storytelling through art are illuminated.

"Keywords:" arts-based research, narrative inquiry, feminism, education, nursing resilience, emotional labour.

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Chapter 1 Introduction

Resilience is a nursing problem, but there needs to be more understanding of the factors that promote or develop it, particularly in nursing education. Nursing resilience research is vital because of the alarming rates which show that nurses are leaving the profession (Draper-Lowe, 2016). Attrition in the nursing workforce, combined with the fact that the population is living longer with many co-morbidities, has contributed to even more stress in healthcare (Cope et al., 2015). Resilience in nursing has been related to less workforce burnout, reduced job stress, less compassion fatigue and turnover, and increased job satisfaction. It is seen as an overall benefit to the nurse (Delgado, 2017). Stacey and Cook (2019) noted that only one study on nursing resilience used qualitative data in a scoping review, and this was just a small part of a more extensive case study. There is a shortage of qualitative research that portrays the personal stories of why nurses remain resilient in the workplace (Cope et al., 2015); there needs to be more research on this subject.

Stacey and Cook (2019) stated that a standard definition of nursing resilience suggested that it is an individual's internal ability to cope and respond confidently to challenging situations. There are a variety of definitions for resilience; in nursing, it is frequently conceptualized as the ability of a nurse to bounce back. It is linked to a stressful situation and compared to an elastic band's ability to return to its original shape once stretched (Riopel, 2020). Commonly stated, resilience is the ability of a person, community, or system to adapt well to challenges and learn from them (Hughes et al., 2021).

I am curious about the relationship between women's work, caring/nursing work, and emotional labour and how this impacts nursing resilience. My professional nursing story began in 1985 when I was a newly graduated Registered Nurse working in a large tertiary care centre in

a post-partum and high-risk labour and delivery unit. I have had times in my career when my resilience was challenged, and I needed to take time away from nursing as I felt the impact of the emotional costs of caring. Hochschild (1983; 2012) first introduced the concept of emotional labour in the literature around caring work and the emotional labour inherent in a caring role. Hochschild posited that caring work, treated as a commodity in a capitalist society, leads to the employee's alienation. Workers are forced to adhere to the structural norms where they are expected to display emotions dictated by the structure that might not be the same as the worker's true feelings.

Nursing scholar Traynor (2019) described that the worker sells their labour, and the capitalist uses it for profit, resulting in worker exploitation and alienation. According to Hochschild, when a profit incentive is applied to emotion, the worker loses control over how the role is incurred, which leaves them feeling that their work is deskilled and undervalued (Johnson, 2015). Delgado et al. (2017) reviewed nursing, resilience, and emotional labour and noted a gap in the literature that examined this. It is crucial to nursing to understand resilient nurses' stories because they are essential and add important insight from their perspective—research about whether emotional labour impacts nursing resilience is an important area to explore.

In the context of the COVID-19 pandemic, the strain on nursing resilience has grown exponentially as nurses face all the work and personal challenges the pandemic has presented. Nursing resilience is not a topic in the nursing curricula; I have chosen the pandemic as one moment in time to explore its role in nursing.

Background

A lack of nursing resilience is one of the causes of low retention rates of nursing personnel (e.g., Draper-Lowe, 2016; Hart et al., 2014). In 2017, hospital turnover rates ranged

from 4.5% to 30.7%, with an average of 18.2%, the highest since 2013 (Wei et al., 2019). Cooper et al. (2020) noted that nursing resilience needs to be sustained, or nursing shortages will impact the maintenance and delivery of safe patient care.

Low retention, culminated with the nursing shortage, will have detrimental effects on health care; therefore, nursing resilience is vital from an educational perspective. It is important to understand how to foster and support resilience in nurses as it concerns educators and the healthcare institution.

Nursing resilience during the COVID-19 pandemic is a new topic in the literature. There are some recent publications of note on the impact that the pandemic will have on nursing –resilience. Duncan (2021) noted that it is vital that nursing leaders acknowledge the long-term effects of the pandemic on the nursing workforce. Duncan stated that building resilience across acute care and public health is critical and calls for nurse leaders to support workplace resilience. None of this information is surprising in a literature review on nursing resilience; what needs to change is a concrete plan to address it from an educational perspective.

The notion of collective resilience is noted in the literature where groups of people in crisis join forces to deal with it, for instance, bystanders during the Boston Marathon bombings or the COVID-19 pandemic (Glynn, 2021). Interpersonal networks of connection emerged amongst the people connected to the crisis. In nursing, collective resilience is not well studied; however, some authors discussed that resilience is supported if nurses feel a strong connection and relationship with their co-workers, which is almost a preventative factor in mitigating burnout and a lack of resilience (Lemoine et al., 2020). A further complication caused by the COVID-19 pandemic is that it has forced the population to cope in ways that do not include face-to-face contact, including nurses. As Collins (2020) stated, virtually all solidarity has been

developed through face-to-face contact and in-person co-presence with others throughout history. This lack of physical closeness and its impact on nursing resilience is not understood.

Some scholars believe that the sexual division of labour has caused enormous stress for working women like nurses (Speedy, 2017). Understanding the stories of resilience within emotional labour in nursing is limited (Delgado et al., 2017). Delgado et al. (2020) completed a quantitative study on emotional labour in mental health nurses using a "Resilience at Work and Emotional Labour Scale" and noted a negative relationship between emotional labour and nursing resilience; a gap remains in qualitative research on the topic.

Riley and Weiss (2016) wrote a thematic analysis of 13 qualitative papers exploring emotional labour in healthcare. They concluded that more support is needed for healthcare providers to deal with emotional labour demands. Van Zyl and Noonan (2018) called for a shift to an emotional curriculum in nursing education to help students develop resiliency strategies proactively rather than react defensively once resilience is challenged. What is needed are details about the factors contributing to nursing resilience; until this is understood, nursing educators will not know how to adapt the nursing education curriculum to maintain the nursing workforce positively and support resilience in the workplace.

Purpose

Through arts-based research and narrative inquiry, I explored nurses' resilience stories with a feminist lens. Feminist research challenges structural and social power inequalities within patriarchal societies that disadvantage women (Davies et al., 2019). It was essential to underpin this research with the feminist theoretical framework because nursing is a predominantly female and a female-gendered occupation (Jamieson et al., 2019). Nursing resilience is vital to the

healthcare system, but little is understood about how best to foster and nurture it from an educational perspective. From this academic perspective, I became interested in this research.

Harris (2018) stated that it is essential in feminist research that the researcher consider the privileges or presuppositions of the questions posed; this is a crucial aspect of this research that I remained mindful of. By placing feminism at the centre of this research, I assessed the impact of power on nursing knowledge formation. Through their stories, I explored how the nurse's gendered role impacted emotional labour and nursing resilience.

I wondered what factors existed in resilient nurses despite significant challenges in their work. This research study intended to give voice to resilient Public Health Nurse stories working within the context of the COVID-19 pandemic. Focusing on their stories, expressed through narrative inquiry and art, I will contribute to the educational research about what fosters and nurtures nursing resilience. Knowledge gained will inform educational policy in nursing education and the institution within which nurses work. Clandinin (2013) stated that the narrative inquirer thinks not of framing a research question but of arranging the pieces to a research puzzle.

I became particularly interested in nurse resilience within the COVID-19 context because I worked in this area as an insider. Public health nurses on the front lines performed COVID testing, managed outbreaks in long-term care, and supported vaccination clinics: these nurses are at the heart of this research. Indeed, as the world was running from this global pandemic, nurses ran toward it. Nurses selflessly set aside their safety for the health of the population. In the context of the COVID-19 pandemic, this time in history was a test for nursing resilience; therefore, this research is essential. These brave nurses should be celebrated and remembered for

their sacrifices and achievements. The nurses I studied had long-standing resilience in nursing, defined as working longer than five years. They self-identified as resilient and feminist.

Research Puzzle

Clandinin (2013) states that narrative inquiry shifts away from the use of research questions prevalent in other methodologies and this distinction makes clear that it is different from other methodologies. As narrative inquirers, we begin in the midst and end in the midst of the experience. Clandinin instead looks at the unfolding, in an iterative way, of a research puzzle.

The focus of this research was: How can nursing education encourage nurses to remain resilient in the profession?

I was interested in exploring how nurses express their personal stories of resilience during COVID-19, how they have nurtured it during their careers and suggestions from them about how nursing education and healthcare institutions can help to support resilience. An important aspect in the development of resilience is barriers to its development, which will be vital to this research.

Emotional labour has been described in the literature as managing feelings that fulfill the job's emotional requirements but may not match what you feel personally. I am interested in if this has impacted the experiences of nursing resilience.

Significance of this Research

In this research, I explored nursing resilience within the context of the COVID-19 pandemic. It contributes to the literature and knowledge that exists to date on nursing resilience during a time that has tested resilience globally. Several authors recommended that there needs to be more research into understanding what promotes resilience (see, e.g., Cope et al., 2015; Draper-Lowe, 2016; McDermid et al., 2016), the investigation into the relationship between

emotional labour and resilience (see, e.g., Delgado et al., 2017; Riley & Weiss 2016) and the need for more qualitative research on the personal stories of nurses who thrive in stressful workplaces (Cope et al., 2015). Additionally, the impact of oppression and voicelessness on nurse resilience is unknown.

I focused this research on the stories of front-line public health nurses who were redeployed from their public health positions during the COVID-19 response. Public health nurses were redeployed first to COVID-19 swabbing units and then to the COVID-19 immunization vaccine rollout. The risk experienced by these nurses was never part of the job description, and nurses faced the threat of COVID-19 daily (Glynn, 2020).

When little was known about the impact and spread of the virus in March 2020, public health nurses risked their own lives for society's good. These nurses worked in various settings managing COVID-19 testing sites while fighting for access to protect themselves with personal protective equipment (PPE) in the workplace (Huncar, A., 2020; Jackson, 2022). In some cases, nurses who spoke out about a lack of safety equipment to protect them from exposure to COVID-19 faced backlash from their employers (Lander, 2020). A year later, nurses continued to meet high-risk exposure levels as they supported and vaccinated client populations in long-term care sites and those at risk for disease from COVID-19. Nurses in public health were not prioritized for vaccination to protect themselves from exposure within these sites and entered these areas at significant risk to their health and safety.

Nurses are true heroes but continue to be undervalued, particularly in Alberta, the location of this research, where, in the middle of a pandemic, the Alberta government threatened layoffs and pay cuts and showed little respect and value for a profession so important (United Nurses of Alberta, 2020 October 21). Banners on hospitals advertising "Heroes work here"

seemed to be more for political advertising than because employers value their healthcare workers. In a show of support, union rallies were held outside Alberta Hospitals in November 2020, in the heart of the growing pandemic, to reinstate pandemic and isolation pay and reverse a decision by the Alberta Government to cut 11,000 Alberta Health Services jobs (Global News, 2020, November 5). The lack of respect for nursing has continued as the Medical Officer of Health, Dr. Deana Hinshaw, received a financial bonus of $228,000 in addition to her $363,000 yearly salary in 2021 (CBC, 2022). United Nurses of Alberta [UNA] have been without a contract since 2020 (UNA, 2022), even though they did ratify a new agreement in January 2022. This contract had remained unsigned by Alberta Health Services as this dissertation is being written in August 2022. The new contract includes retroactive pay and a small COVID-19 hazard pay allowance that nurses have yet to receive (UNA, personal communication, August 11, 2022). The media continues to spread a narrative that nursing retention comes down to issues about wages (CBC, 2021; CTV, 2021), but this seems a simplistic conclusion to a complex question. This research examined nursing retention and resilience in a complex and meaningful way from the point of view of nurses who worked during the pandemic.

A vital aspect of this research has been the artistic collage that research participants used to express their thoughts and feelings about nursing resilience. Also important were the research participant's artist statements, which added to the visual data, all of which articulated deep levels of meaning.

The study of resilience in public health nurses working during the COVID-19 pandemic will illuminate knowledge on resilience. I wondered how public health nurses foster and nurture resilience in a stressful and potentially lethal work environment. Despite the professional challenges, some nurses foster close and life-long friendships with their nursing colleagues and

cannot imagine doing anything else. These resilience stories will contribute to research in this area, disseminated in nursing education. The use of art in uncovering meaning will also add to the knowledge about the use of art in research.

This dissertation is presented in eight chapters. In Chapter 1, I introduce the topic of nursing resilience, the background and purpose of this research, my research puzzle and why this topic is of significance to the profession and society collectively.

In chapter 2, I recount my narrative beginnings, an essential aspect of this narrative inquiry as I live amid my own story of nursing resilience and the stories of resilience shared by the research participants.

In Chapter 3, I present the literature review on nursing resilience: I review several vital factors, like emotional labour and the link between women's work and nursing, the patriarchy, feminism and subservience in nursing and the impact of poor retention on nursing. Several factors connected to nursing resilience are reviewed, like mentorship, how nurses learn, self-care, and recent literature on factors that affected nursing resilience during the COVID-19 pandemic.

In Chapter 4, I present the methodology and theoretical framework that will guide and underpin this research and defend why these are integral within this research landscape on nursing resilience. Narrative inquiry, art-based research, and the feminist theoretical framework are discussed, along with how these guided this research study about nursing resilience. The research design, data collection methods, and analysis are shared in this chapter and tailored to this narrative inquiry.

Chapter 5 presents the narrative stories of the four research participants; these nurses worked through the pandemic and expressed powerful stories about their experiences. In addition to the written texts of their stories of nursing resilience, this chapter includes the collages and

artist statements that research participants created about their experiences working during the COVID-19 pandemic. These visual stories insightfully portray their experiences during this time in history.

Chapter 6 elucidates and weaves together narrative threads evident in this research. I present a pictorial weaving of these resonant threads in a collage in this chapter and proceed through the stories I shared in the research relationship. I was humbled to give voice to these stories and share them within this dissertation.

Chapter 7 illuminates this research and discusses it relative to the literature on nursing resilience. This is important because it will illustrate what this research will contribute to nursing and nursing education.

In Chapter 8, I pose a series of questions about where changes might be made regarding resilience as well as implications for further research on nursing resilience and discuss my subjectivity. Nursing resilience is a timely topic not only due to the nursing shortage but also because of the impact that the pandemic has had on resilience.

Chapter 2 Narrative Beginning: Placing Myself in the Midst

In this doctoral dissertation, I share nursing stories of resilience from 4 nurses who worked within the context of the COVID-19 pandemic; this is the landscape of this inquiry. The starting point of this journey is my narrative beginnings. As Clandinin (2013) stated, the research must outline the narrative inquirer's personal, practical and social justifications for their research. In the following sections, I outline my justifications for this research: my personal practical and social reasons. I then outline in depth my positionality, and in so doing, I will paint a picture of my past and present as I live this story of nursing resilience alongside and in the midst with the research participants.

Clandinin (2013) denoted that the starting point of any narrative inquiry is its narrative beginnings. She stated that, at the beginning of any narrative inquiry, the researcher must outline their own stories, their relationship with their research interest and their reasonings for engaging in a particular inquiry. My story speaks to some experiences in my life that have informed my past, present and future but is not an exhaustive list. There may also be counternarratives that exist, but this narrative inquiry focuses on the 4 nurses in this study and my own story of nursing resilience. This describes my reasoning for engaging in this narrative inquiry and gives more information about how I came to be where I was in the midst while conducting this research. Clandinin stated that narrative inquiry is an ongoing reflexive and reflective methodology; narrative inquirers must continually inquire into their experiences before, during, and after the inquiry.

Situating Myself

My storied experience of nursing resilience within the context of my own life will expose the tensions I have felt working as a nurse, including my resigning twice from the healthcare institution. These experiences make me more attuned to the stories of resilience shared by the research participants: although our journeys may differ, there will be places where our journeys have been similar. From a practical perspective, the challenges to resilience need to be exposed and shared to inform and keep nurses in the profession. As Traynor (2019) stated, it is not appropriate to solely blame the individual nurse for their lack of resilience without exploring other variables that might influence this from a systemic perspective. My social justifications for this inquiry: I hope that, through sharing these stories of nursing resilience, changes in policy around resilience will be made within the healthcare institution. It will also suggest ways to better support resilience in nursing education. I know that in my experience obtaining my registered nurse designation in 1985, there was no discussion of nursing resilience. Instead, my nursing education experience encouraged me to hide my emotions as that was how to support my patients in the most caring way. I was accustomed to this idea, however, as I was not encouraged as a child to share my feelings or opinion as a female, so, at the time, I didn't question this philosophy.

As I engage in this narrative beginning, I will expose, to a certain extent, my biases and explain why I have embarked on this research about nursing resilience. As I thought about this, I realized why this research was particularly interesting to me. I am currently venturing into the field of nursing academia, and I have paid the price for challenges to my financial and emotional resilience in my career. It may seem somewhat counterintuitive for someone with my negative

experiences to be a resilience researcher, but my story does show that I am resilient. I have embarked on this journey because of my insight into the topic. I look forward to sharing my story of resilience and those of the research participants; these are my justifications for this research.

Positionality

Qualitative researchers attest that researcher positionality is impacted by race, gender, social class, and sexual orientation. For instance, my positionality is influenced by the culture I was born in, the nursing culture I work in, and the cultural context I live in. I was born into a rural farming family on the Canadian prairies. We lived within minimal means; one thing I did receive from my parents with great abundance was a love and respect for education. We were encouraged from a young age to seek educational opportunities. I recall my father telling me that education would significantly benefit me. He never had a chance to access higher education: he worked on his family's farm and then on his own. Although formal education was not possible for him, it was something that he encouraged his children to pursue.

I recall my father listening exclusively to the Canadian Broadcasting Corporation [CBC] radio and spending hours reading about history and current affairs. These activities bolstered his intellect, and he challenged my Great Uncle Woodrow to epic debates on politics and the Cooperative Commonwealth Federation [CCF], which later became the New Democratic Party, around my parents' kitchen table. These experiences influenced my view of education and have helped me positively influence others as I have served as a role model personally and professionally.

When I reflect on my nursing career, I recall thinking how lucky I was to support new families during a joyful time. Overall, I look back on my career and feel blessed, but I acknowledge that some experiences tested my resilience. For instance, as a new graduate, I

supported a 13-year-old through the delivery of her expired infant with no support from older colleagues. I worked in a high-risk climate and experienced bullying and derogatory comments from senior nurses and hospital staff with little to no mentorship or support. My resilience was certainly tested more by women than men, and I have always wondered why, as women, we don't always support each other. I have seen new nursing graduates be unsupported by senior staff even though it would seem to be we should care for each other. Despite these stressful experiences, I maintained my resilience for 15 years before I resigned from the institution for the first time. In those 15 years, I developed a strong sense of my caring role, values, and advocacy. Although there were difficult days, I loved my job.

I have applied a love and respect for education in my work as a public health nurse. In my practice in schools and in working with young families, I have been able to, for instance, promote healthy eating so students in schools can learn with increased capacity. In my work with young families, I have supported referrals to agencies so immigrant women and single mothers could access education. Through this Ph.D. program, I hope to influence nurse education to consider ways to support resilience so that students feel well-supported and experience the joy of a caring relationship. I am philosophically aligned with John Dewey and his theoretical view of experience being built upon previous experience. Dewey (1916) stated that all that schools need do for students is to develop their ability to think. This is particularly important in nursing education because nurses need to think quickly in their work, if we teach them how to think this is integral.

Prominent feminist researcher Hesse-Biber (2012) acknowledged the work of emotional labour in female-gendered caring work. Hess-Biber agreed with Hochschild's (1983; 2012) idea that anger in society tends to flow down the social hierarchy and that love flows upward. For

example, nurses are near the bottom of the medical patriarchy. The medical authority dictates medical decisions, not nurses. Power flows downward, and nurses' loving and caring work flows up the hierarchy.

The biomedical model has shaped nursing with patriarchal influences (Aranda, 2016; Mitchell, 2017) and the nursing culture has influenced me. As a newly graduated nurse, I recall how the medical profession dominated nursing. For example, nurses were expected to vacate their chairs when doctors entered, and nurses only referred to them by their official “Doctor” titles.

The collage attached in Figure 1 expresses my feelings about working as a nurse within the medical patriarchy in health. As a nurse, I have felt the power and dominance over me; I have felt silenced, voiceless, powerless, and alone. I am ethically bound to advocate as a caregiver to provide safe and competent care. Love, caring, kindness and healing emanate from me. Nurses must advocate for their patients while being threatened by the power structure in the institution. Despite my stress and trauma from my experiences, I remain resilient and strive to give voice to a field that historically has had none. The image of control is powerful; the power dynamic has been palpable in my nursing career, originating from both the medical institution and nursing administrators within the institution. The following stories will help demonstrate some experiences that have shaped me.

Figure 1.

Power and Control over Nursing

Artist statement:

This demonstrates my lived experience as a nurse within the medical patriarchy in health. As a nurse I have felt the power and dominance over my profession, at times I have felt silent, voiceless, powerless and alone. As a nurse I am bound ethically to advocate as a caregiver to provide safe and competent care. Love, caring, kindness and healing emanates from me. Nurses are put in positions where we must advocate for our patients while being threatened by the power structure. In spite of my own stress and trauma from my experiences I continue to be resilient and strive to give voice to a field which historically has had none.

Get Me a Nurse Who Will

This first story I will share was a monumental one in my career and the first actual test of my resiliency. One weekend I was caring for a lovely couple having their first baby. I had been a nurse in labour and delivery for about ten years. As a nurse in labour and delivery, I was innately attuned to the administration of safe and competent care. My nursing education emphasized the

delivery of safe care; families placed themselves into my hands in a vulnerable time while they looked forward to meeting their new baby, and I took this very seriously.

I knew by this time in my career that many things could go wrong in this space and time, and some tragedies could unfold. To the best of my ability, I kept the families I worked with safe. I recall sitting with my patients in the bathroom, in the shower or wherever they were most comfortable during their labour. I was well versed in what constituted safe care, what policies governed this and what the roles and expectations were for myself and the medical team. I knew that as a nurse, one of my crucial roles was patient advocacy; my connection to this role is exhibited in the following story.

This experience continues to inform my nursing identity which is based on caring and advocacy. What made it monumental was the depth of my concern for the patient's safety. At this time, I had worked in a small regional hospital. The family doctor on call wanted to use an assistive device to speed up the labour and delivery before my patient was dilated. I knew from experience that this was against policy, especially in a case where there was no fetal distress, everything was proceeding normally, and there were no red flags and no reason for expedited delivery. When the doctor asked me to assist him with using the vacuum extractor to hasten delivery, I was stunned. I knew that policy governed that it could not be used; to do so could cause perilous tears that could threaten the patient's life. As I requested to speak to the doctor outside and shared my grave concerns about his plan, he demanded that I get a nurse to help him.

This exchange expressed the medical establishment's power and control over me, he was shocked to be questioned or thought I would respond to his demands. This day was a new experience for him as I stood my ground. He eventually agreed to consult with an obstetrician, which was my ultimate goal. I remain grateful for the support of a senior nurse I worked with

that day; with her help, we shared what was happening with the charge nurse and nursing supervisor. The outcome for the family that day was a happy one; the family delivered a healthy baby several hours later. The story, however, does not end there. The doctor I questioned tried to have me fired over the case. In the doctor's orders on the patient's chart which typically shares patient specific doctor orders the doctor named the senior nurse and me and in it he wrote that we should be fired for insubordination. His comments about us remain a part of the permanent record on this patient's chart.

I was not on shift for several days after this experience, and I had waited for a call from our nurse manager the following week. Nursing units all have a nursing manager, sometimes more than one, who manages the budget, nurse scheduling and deals with the day-to-day decisions about how a nursing unit is organized. In a hospital they are the direct link to the medical staff. I was looking for some assurance and, to a certain extent, positive recognition. When I did not hear from the nurse manager, I thought I might be fired; this was a small city hospital with the medical patriarchy powerfully in control.

Eventually, late that week, I called the manager myself. She said that the Medical Director had been to the unit, he looked at the chart, and there was never any further mention of it. When I did not hear from the nurse manager, I wondered why she had not called me to see how I was doing. I know a friend said I was viewed as a bit of a hero on the unit that week. Funny, I did not feel like a hero; managerial support would have helped me immensely to deal with the stress of this experience.

When I worked on the collage in Figure 1, I depicted the nurse that I was that day in my story, and I felt all the feelings that I still, to some extent, feel; this event in my past has informed who I am today. I do not think I ever got over the impact of that day and the days that followed.

This experience laid the groundwork for my thoughts about advocacy and my commitment to safe patient care. I am sad to share that this is not the only time I have had similar experiences working as a nurse. Fortunately, after this, I developed confidence in my advocacy skills and continued to maintain my commitment to safe patient care.

I know from my own experience that emotional labour is a reality. I recall in detail some of the faces of the people I have cared for:

- the families who have lost babies;
- the women who thought they would die in childbirth;
- the dads with whom I shared troubling news regarding their loved ones.

I know there needs to be more acknowledgment of the relationship between emotional labour and resilience in health care, so this research is critical. This study adds to the knowledge and theory of this vitally important aspect of the profession.

The Healing Nature of Art

A second significant story I will share led me to resign from the profession the first time. As I have shared, I built my career on the foundation of safe patient care. I spent most of my shifts in the presence of my patients as I supported them during labour and delivery. I developed caring and close relationships with them and shared their joy as their babies were born. I would commonly stay overtime to get a chance to meet the new baby as it felt like I would miss out on the joy of the delivery if I went home before it happened. This story begins on a weekend shift after I was nursing for 15 years and takes place at the small city hospital I described in the first narrative story.

I will not share details of what happened that day except that my care for the family involved was attuned to my high standards. Still, there was a poor outcome and a perilously sick

child. I maintained a semblance of order in my life as I had small children at the time but resolved after a few months that I needed to resign; my resilience was utterly spent. Reflecting on my emotions and examining this experience temporally, I have realized something important. My story of being a caring nurse was closely linked to my self-worth. This experience disrupted this link in my identity as a devoted nurse, and I did not know how to work without this identity.

I sought solace in my art, and it was then that I returned to post-secondary school and achieved my diploma in art and textile design. More than anything, this time spent working in art healed me from this challenge to my resilience.

I returned to nursing after I moved with my family to a large city, and I returned to working in labour and delivery. When I was recovering from the stress of working as a nurse and being unemployed, our family had paid a financial cost. This led me to decide to go back to nursing as I needed to help support my family. I hoped that working in a large city hospital would be a positive experience, and indeed it was. In this city hospital, nurses and doctors worked as part of a cohesive and collaborative team. It was during this time I completed a nursing degree; up to this point, I had worked as an RN without a degree. Once I completed my nursing degree, I started working in public health. This role aligned well with my commitment to a primary prevention focus in the community.

In my master's degree research in 2015, I began to explore the use of art in research. I was apprehensive about it; I had kept my art private; it represented a quiet place where I could formulate resolutions. It was a healing place. It was not until I reflected on the impact that art had on me that I realized my journey into arts-based research. When my work experiences severely tested my nursing resilience, art kept me sane; I wondered how the use of art could be used to express feelings about nursing resilience in the research participants.

Art has shaped my positionality; as a youngster growing up miles from friends, I spent hours working on drawings and getting lost in the creative world. These experiences gave me a unique insight that has helped me use art in research.

I see the world through a plurality of meanings. At times I think that this Ph.D., although undoubtedly a significant achievement, needs to be acknowledged as a pathway toward my own healing. It has brought me and the research participants peace and allowed them to tell their stories. I am fortunate to be where I am today; I have learned from these significant challenges.

I am a nurse who has remained resilient in the field over the long term. Still, I have experienced emotional trauma in the workplace, resulting in my own experiences of burnout and a loss of resilience. There have been significant times when I had to find ways to cope with the emotional toll that working as a nurse has had on me personally and professionally. Indeed, this is also an inspiring factor for my passion and interest in the topic.

I am a registered nurse and uniquely positioned in this research study on resilient nurses because I have had times when my resilience was tested, but I remained devoted to the work. The patriarchal medical establishment has threatened me for daring to question unsafe interventions while I advocated for safe patient care. The institution has made me feel like I am disposable and voiceless. Conversely, I have been privileged to bear witness to and care for people in times in their lives that have been both devastating and joyful: I consider myself quite honoured to have shared these experiences. I believe I received positive benefits through the caring relationships I developed; I benefited from my caring role. When the benefits of staying in the profession were no longer worth it, I had nothing left to give.

The Pandemic

After attaining my master's degree in Adult Education, I left public health nursing to work in Women's Health. I returned to public health temporarily in August 2020 during the height of the pandemic and before a vaccine for COVID-19 became available. I was excited to return to public health nursing, but I recall the first day of my return to an ominously quiet office; all school health nurses were still working at the COVID-19 testing centres. The healthcare institution referred to the re-assignment and movement of staff from one area to another during the pandemic as an order, a redeployment. Reassignment would have been a more humane way to refer to being moved to a different area but the fact that nursing management chose to use the term redeployment speaks to the bureaucratic dominance and power over nursing. I could feel a deep sense of exhaustion among the few office staff that remained; the usual banter and joking among the team were gone. As redeployed nursing staff returned to their public health positions, I decorated their desks with small desk signs that stated, "I'm kind of a big deal," and I made sure there was a thank-you card and homemade fudge as a welcome. I felt this small gesture was the least I could do as each nurse shared stories of their awful experiences while working in the COVID-19 testing centres. The nurses appreciated my welcome for them, nursing management never acknowledged this gesture.

At the end of December 2020, as the new vaccine became available to long-term care sites that were the most vulnerable, public health nurses began supporting the introduction of the vaccine for COVID-19. I spent New Year's Eve 2020 helping long-term care sites, that had experienced the worst active outbreaks, receive the vaccine. As I strolled through the corridors at these sites, isolation signs were hung on the doors of shared rooms. Residents with dementia were walking around without masks even though it was evident they were in the middle of an

outbreak. I recall feeling a sense of deep sadness for how vulnerable these grandparents of our society were. I cried with the nursing staff there on the first day the vaccine became available for their patients. There was a mix of excitement that the vaccine was finally there but also sadness for all the clients they had known who had died from COVID-19. I revelled in the nurses' stories about the clients in the care home crying because they found out they would receive the vaccine that day; many had not seen their families since March 2020 as the lockdown began. Families on New Year's Eve visited their loved ones outside the windows of the residents' rooms, unable to see and embrace them in person. I prayed that this would be the last New Year's Eve they would have to spend alone waving at their family, who stood outside their window.

I recalled feeling insignificant that first night at the long-term care site when my manager told me by phone that, once all patients and care home staff were vaccinated, leftover doses of vaccine would be disposed of. I questioned why we could not save them for transport or vaccinate the nursing team I had with me. The public health manager told me that our public health nursing staff could not be immunized with leftover doses; the excess vaccine would be incinerated even though the vaccine would have been safe to use if refrigerated for up to a month. The care sites had many areas of COVID-19 outbreaks; in dementia units with outbreaks, I was at significant risk for COVID-19. Still, nurses were not deemed worthy enough to be vaccinated; this led me to believe that I was not a priority in the institution. I felt powerless; I did not have any power to advocate for my safety through immunization, and no one in the institution would listen.

Public health nurses supported the long-term care sites with two vaccine doses, but this relationship with the care sites continued. There had been so many deaths that there was a constant shuffle of clients into beds vacated because of COVID-19 deaths. Our care home role

was complex and pushed me outside my usual role as a school public health nurse. The days at the care home were a whirlwind; ensuring we kept track of every single dose made the job stressful. I recall being exhausted at the end of each day, which carried on for many months.

Once the long-term care homes had been completed, public health nurses moved into other care home sites. Even when I was home, I answered many calls from nursing management who wanted me to work in other areas or extra shifts; it was never-ending. I felt like I could not escape the pandemic, even during my off hours.

After the care homes, public health nurses were shifted to working in the COVID-19 immunization clinics. This was probably the most challenging time for me as I felt increasingly dehumanized by how nursing staff were treated. I experienced ethical tensions when one of the charge nurses told me that the manager of the vaccine clinic had said that nurses only had six minutes per client. I responded to her, "If it's safe?" I felt significant tension about this demand because my nursing values dictated that I complete an informed consent and a proper fit to vaccinate. This was also a legal obligation to which I was bound, which was impossible in six minutes. Clients had many questions about the vaccine for COVID-19, and I needed to answer them to help them make an informed choice. The command for speed dictated by the institution created tension as it bumped up against my nursing values. I struggled with the institution's extra demands and challenges and knew I was being watched. This experience deeply impacted my ability to remain resilient and feel valued as an experienced public health nurse.

Working during the pandemic was difficult, although I found initially that the public celebrated nurses with musical tributes at 6 PM daily (Elliot, 2020). These tributes did energize me; however, as the pandemic continued, the public became less enthusiastic about nursing and healthcare efforts, which manifested in poor and troubling behaviour. Many times, when

working at the immunization clinic, I was berated and yelled at if the client could not get the brand of vaccine they wanted or if they were angry about the vaccine mandate.

At the end of the clinic each day, we were warned to be careful walking to our cars because antivaccine protesters were outside where we worked. No extra security was provided for us; we were only told to exit in groups. I remember hiding my badge so I could not be easily identified as a nurse. This made me feel discouraged about my sacrifice to support public health work. Nurses were verbally abused while going to work in many regions globally, and there were calls for zero tolerance for such abuse (Reuters, 2020). From my perspective, the people who were the most poorly behaved got what they wanted in the clinics, which probably added to my struggle with the work we had accomplished as a group. Our efforts to provide vaccination helped the world get to the point where COVID-19 became less life-threatening. It felt that the world became less appreciative of our efforts as professionals while being treated like we were disposable by the institution.

I chose this profession because of my commitment to caring for and supporting people in need. Nurses were required to do more in the past two years of the pandemic than ever before; many days, it felt like I was doing the work of three nurses. Why do I do it? I think it is a part of me, and I am a part of it, an almost symbiotic relationship. Yes, it is challenging, yes, it is an actual test for us all, and yes, there is fear, but this has also given me many rewarding moments.

A Final Test with the Institution

The final test of my resilience, which led me to resign from the institution a second time in my career, happened in June 2021. I had interviewed for a permanent job in public health as, despite the challenges faced, I wanted to remain there until I had completed my Ph.D. My temporary position had ended there; I had embraced and held leadership roles, made outstanding

achievements in community development, completed a master's degree and was a Ph.D. candidate. I have over 35 years of nursing experience ranging from high-risk labour and delivery to post-partum and well-child school health. After my interview, the nursing manager told me that I did not interview as well as the successful candidate who had less than a few months in the role. I found this experience intolerable. I acknowledge that I had difficulty abstracting meaning from this experience because my professional identity had been linked to working hard; I thought I would be rewarded for that. This idea comes from my upbringing and my experiences to date. Perhaps I had been passed over for a permanent position in public health because I asked questions when tensions bumped up against my sense of professional responsibility. I felt like I had been dismissed by nursing management, who no longer needed me, and I felt disposable. I felt like I was a victim of the power and control of the institution. I could no longer tolerate being devalued and dismissed in this way. My resilience was spent, and I decided to retire. None of the nurse managers signed the card that the nursing staff organized, wishing me well. There were no thanks for a lifetime of caring. I still feel great sadness that this was how my career working for the institution ended.

I sought solace in the fact that I had attained a sessional adjunct lecturer role with a prominent university starting the week after my retirement. As I was negotiating the bump up to my understanding of my professional identity as a nurse, I began re-storying my life. Clandinin (2013) noted interruptions in narrative coherence that cause one to re-story one's life. As I reflected on this concept, I realized that I had gone through the process of re-storying my life a few times. As I have moved toward an academic identity, I have enjoyed working with the next generation of nursing students in post-secondary. I hope that with my experience, I can support their pathways to resilience.

Academia

I am aware that I have not yet identified with the academic educator role as this is much different from my work life historically. When I began my Ph.D. program in 2019, I felt like an outsider, questioning whether I had earned the credentials to pursue this level of education, "What have I done?" I thought at times that I did not belong here. As I entered the classroom on the first morning in the Ph.D. program a few years ago, I scanned the room for a place to sit and landed on an empty chair beside a woman in her 30s. I thought, "That looks like a good spot," and I sat down. I retained my composure while that little voice in my head kept asking me, "What are you doing here?" Shortly after I sat down, the woman I sat beside leaned toward me and said, "I don't know about you, but I am feeling a strong sense of imposter syndrome." I remember beaming as I responded, "Me too!" I was still bumping up against whom I thought I was and my nursing identity and wondering if I belonged in academia. This will become a part of my story as it shapes my future. Jagsi and Mullangi (2019) argue that imposter syndrome is a psychological term that refers to a pattern of behaviour where people doubt their abilities and fear that they will be exposed as a fraud. From a feminist perspective, this behaviour occurs more often in women and minority groups because they often lack models of success. Although uncomfortable, my move into academia has required some time to feel like I belong here as I struggle to develop a new identity as an educator.

Positionality is especially important in the conduct of critical research. I am a nurse who was a part of the group I was studying. Clandinin (2013) stated that a researcher needs to support the reason for their research with justifications to answer the "so what" and "who cares" questions. I hope that sharing the research participants' stories will support their healing journey post-pandemic. I hope this research will help us consider changes to support vital resilience for

society's sake. Indeed, this is my justification for this research. Talking about issues like resilience raises consciousness, which may promote healing and can invite change.

Chapter 3 Literature Review

This literature review provides an overview of nursing resilience, feminist theoretical framework, emotional labour and COVID-19 research. Literature examining the importance of mentorship, self-care, and recent literature on nursing resilience during the pandemic is included. These areas of research have helped to inform this Ph.D. dissertation research.

I have included recent literature published, exceptions to this inclusion criteria include dated but relevant feminist literature like Harding (1987), Lather (1991), Hesse-Biber (2013), Chinn and Wheeler (1985) and Jackson and Daly (2004). Excluded were non-English language papers and quantitative research studies. This review was completed by searching databases in the fields of adult education and nursing, feminism, emotional labour, arts-based research, and narrative inquiry, utilizing search terms like “Nursing” AND “Feminism” AND “resilience” AND “arts-based research” AND “feminist research” AND “voice” AND “women’s work” AND “caring work” AND “emotional labour” AND “narrative inquiry” AND “COVID-19” AND “self-care”. I searched electronic databases: EBCSCO (Cinahl), ProQuest, Pub-Med, ERIC, Sage, Google Scholar, conference proceedings for the Canadian Association for the Study of Adult Education (CASAE), Dissertation theses through the Library and Archives Canada, as well as the Novanet database for books on the topics. I considered peer-reviewed journals for inclusion and sourced authors from worldwide contexts, including Canada, The United States, The United Kingdom, Singapore, Australia, and New Zealand, to achieve a broad-based and holistic field picture. This broad perspective is essential because nursing is holistic, and it is crucial to understand nursing resilience in a broad worldwide context to see if it varies globally. I considered the author’s scholarly reputation, the quality of the arguments presented, and whether they represented unique interpretations that would contribute to the scope of this analysis.

Impact of Poor Retention, Nursing Shortage, and Burnout

Important themes noted in the literature on nursing include the impact of low retention and the nursing shortage on burnout. Also discussed are nurses' work and women's work, emotional labour, and nursing oppression by the medical patriarchy, hence the importance of nursing resilience.

The nursing shortage is a worldwide phenomenon. For example, by 2025, the nursing shortage in the United States will surge to 260,000–400,000 nurses, affecting safe patient care outcomes (Draper-Lowe, 2016). Recent data suggest 40,000 registered nurse vacancies (Stephenson, 2019). There will be a shortage of 100,000 nurses in Australia by 2025 (El Haddad et al., 2017), while in New Zealand, 46% of the nursing workforce was 50 years old in 2014 (Moloney et al., 2018). Scheffler and Arnold (2019), in a 2018 analysis, predicted a shortage of 117,600 nurses in Canada by 2030. The World Health Organization [WHO] (2020) challenged the world to provide a climate where nurses are encouraged to be attracted and retained in the profession. These statistics show how important it is to address the reasons for poor retention and burnout. None of these statistics take into account the impact of the COVID-19 pandemic on these the rates of attrition of nurses in the workforce.

Nurses form the largest occupational group in health, and its workforce is ageing and retiring at a rate that exceeds its abilities to keep up with the education of a new workforce (Cope et al., 2015). The cumulative effect of retiring registered nurses and the low retention of newly graduated nurses due to burnout has a detrimental impact on the nursing profession (Draper-Lowe, 2016). Çamveren et al. (2020) stated that new graduate nurses are more likely to leave the workforce, especially in the first year, which they conclude is due to a lack of support from managers and colleagues during their transition period from student to graduate.

Nurses often work in stressful environments, leaving them open to physical and psychological stressors: post-traumatic stress disorder, anxiety, depression, substance abuse, and poor decision-making (Draper-Lowe, 2016). Perry et al. (2017) reported that the nursing workforce experiences the highest illness rates of any other discipline; even with this knowledge, healthcare management has little investment in workplace health promotion. These circumstances deserve recognition and point to the imperative for research to explore nurse resilience: insights into nurse resilience are essential to address documented attrition and burnout (Cope et al., 2015).

Nurses' Work and Women's Work

There is a recognized link in the literature between nurses' work and women's work, and it is noted that both are undervalued in society (Eliason, 2017). Historically, nursing is viewed as a caring profession that is subservient and responsive to other professionals' instructions and orders, mainly physicians (e.g., Mitchell, 2017; Tayray, 2009). Nurses historically were seen to have no knowledge of their own; they were guided by the practices and principles of the biomedical model and its androcentric origins (Aranda, 2016). Scholars have argued that nursing work was bound to an ideology based on women's duty, not women's rights (Kane & Thomas, 2000).

The notion of caring in nursing was elucidated by Canadian nursing scholar Sister Simone Roach, author of the *Human Act of Caring* and member of the Congregation of the Sisters of Saint Martha in Antigonish, Nova Scotia (Myers, 2013). Sister Simone's *Theory of Caring* laid the foundation for the United States and United Kingdom codes of ethics for nurses. The Canadian Nurse's Association Code of Ethics was first published in 1980 (Villeneuve et al., 2016). This nursing theory outlined how caring in nursing could be translated into practice

through her 6 C's: compassion, competence, confidence, conscience, commitment, and comportment (Baillie, 2017; Roach, 2013). Sister Simone began to write the theory as she worked as the Chair of the Faculty of Nursing at St. Francis Xavier University (Myers, 2013). In Roach's view, nurses care not because they are in a caring field but because caring is a significant trait aligned with being human (Bradshaw, 2016) and is the core of nursing (Baillie, 2017). Sister Simone saw nursing education as the process that professionalizes the nursing student's capacity to care, and she proposed that caring could be taught (Myers, 2013). Sister Simone's caring theory teaches nurses how to be caring (Villeneuve et al., 2016).

Nursing has traditionally reinforced the idea of caring as women's work (Attenborough et al., 2019). Like women's work, nurses' work remains invisible and undervalued, meaning it is done on the margins with little acknowledgement (Mitchell, 2017). Johnson (2015) stated that researchers in nursing noted a lack of exposure in the literature to the hidden nature of emotional caring work, resulting in its undervaluation by those who work in medicine and the nurses themselves.

The undervaluing of the caring role is related to how nursing developed in society. Historically, nursing developed as an extension of middle-class women's domestic role, and this gender stereotype of nurses' work and women's work spread globally. Jamieson et al. (2019) described nursing as one of the most strongly sex-typed occupations because it is associated with the idea that a nurse's work is affiliated with female caring. It remains primarily female practitioner-based, compounding the sex stereotyping.

One of the disadvantages of a profession like nursing identifying with a caring role is that it is undervalued because caring is seen as natural for women, resulting in the undervaluing of caring work. Traynor (2019) noted that the undervaluing of caring work is exploitive to nurses

and that nursing development has lost its autonomy; caring is linked to the female gender. When nurses' work became linked to and associated with women and caring work, it became less important than men's (Eliason, 2017). Feminist "ethics of care" recognizes that caring work is undervalued because it is linked with emotion and with those who are disadvantaged in society (Parton, 2003).

The undervaluation of women's work is one of the leading causes of the gender pay gap; professions that attract women will be paid less (Sandberg et al., 2018). The undervaluation holds a prominent and discriminatory place within the nursing field that continues in contemporary society. It remains to be seen what the impact of this undervaluation has on nursing and nursing resilience.

Kallio (2022) noted that having a calling to nursing has been historically seen as a risk because it was then assumed that nurses held an oppressed position in society where they had low pay and poor working conditions. This author stated that a calling to nursing can exist, and it can be beneficial to the individual nurse, but that society in general needs to realize that a calling is a positive attribute for a profession. This could lead to an improved sense of professional identity for the profession. Kristoffersen (2021) explored the link between a professional identity in nursing and nursing resilience and concluded that there needed to be more research on the relationship between the two. This author suggested that realizing oneself as a nurse and doing good for the patient seems to be positively linked to remaining in the profession.

The nurse's inter-relationship and identity as a woman have been challenging to change, even with men's introduction to nursing. Jamieson et al. (2019) noted that even though there are men in nursing, they are often identified as the "male nurse." Blackley et al. (2019) indicated that male nurses experience gender role conflict and feelings of exclusion in their work because the

caring role is still closely identified with the female gender. The WHO (2020) noted that 90% of the nursing population is female. Women in nursing leadership face the same gender pay gap bias and other gender-biased work discrimination. Allen and Smith (2016) noted that men in nursing are more likely to ascend quickly to leadership roles and attain a higher status and pay, even though men in nursing in the United Kingdom account for only 9–11% of the total population.

Stilwell (2019) stated that centuries of subservience and subordination by nurses to the patriarchal medical model of health had left nurses with a tendency to overlook their value. Because nurses' caring work has been undervalued for so long, there is an inference by politicians and health leadership that nurses are a disposable resource that can easily be replaced. According to Stillwell, healthcare managers assume that there will always be more women to fill the gap in the nursing workforce.

Emotional Labour in Nursing

The concept of emotional labour is noted in recent nursing literature, and the literature questions the relationship between it and nursing resilience. Caring work is considered a quality that women possess naturally, and emotional labour, defined as managing feelings and emotions to perform the nursing role, is seen as something a "good" nurse provides. According to Traynor (2019), it is assumed that caring work performed by the nurse does not require any particular skill or knowledge.

Emotional labour, spoken of in many ways was first described by Arlie Hochschild (1983; 2012), was defined as the management of feelings that create facial and bodily expressions sanctioned by the employer: workers manage their emotions and display them in exchange for a wage. Hochschild described two types of emotional labour: surface acting and

deep acting. Surface acting, she explained, is the modification and control of emotional expressions, the outward expressions seen. The second, deep acting, involves managing inner feelings that the worker adjusts to meet the mandated display rules. Hochschild inferred that surface acting was a detriment to the employee's well-being.

Allen and Smith (2016) applied the concept of emotional labour to the nursing context. They stated that nurses experience emotions they cannot express, which leads to stress and alienation because their inner self does not match what they are expected to show. The stress and separation cause a level of detachment from caring and trauma.

Theodosius (2008) applied emotional labour theory to nursing and argued that emotional labour has become marginalized in nursing because of organizational changes leading to increased pace and acuity: patients in the hospital have more complex care demands. Shift nurses, it was noted, had no time for the emotional care of their patients. Allen and Smith (2016) stated that nurses are divided between the job's technical demands and the caring work they want to do, which causes care deficits. As a result, nurses must choose to alter their care plans to meet the organization’s expectations.

Humphrey et al. (2015) acknowledged that, due to emotional labour, the employee might feel a loss of identity because their emotions are mandated as a commodity to the employer. Likewise, Holtz et al. (2018) explained that nurses feel moral distress due to making care choices counterintuitive to their moral beliefs. These authors recommended that healthcare systems find ways to develop moral resilience and stated that, although moral distress is acknowledged, it is not well studied.

Theodosius (2008) maintained that emotional labour is primarily invisible in nursing because it has developed alongside the notion of women’s caring work. Humphrey et al. (2015)

examined the concept of emotional labour and concluded that if the job was well suited to the employee, emotional labour's impact did not affect job performance. As Hochschild had (1983;2012) described, these researchers also assert that surface acting harms the employee's well-being.

Dill et al. (2016) explored the relationship between altruistic motivation in nursing and longevity in the field. They found that nurses who reported becoming nurses to care for people were more likely to express a lack of resilience and report more job burnout. Delgado et al. (2020) noted that surface acting was negatively associated with mental health nurses' workplace resilience. This means that the more the mental health nurse adjusts their outward emotions, the less resilience they have.

Emotional labour spent by healthcare workers is not widely accepted as harming resilience and so has not attracted special training to help healthcare professionals to cope with it (Załuski et al., 2018). Delgado et al. (2017) called for more research into the relationship between resilience and emotional labour in nursing because there is insufficient understanding in the literature. These authors state that there had not been any reviews about resilience within the context of emotional labour.

Elliot (2017) and Riley and Weiss (2016) argued that as emotional labour in nursing becomes more recognized, nurses will have more support and strategies to curtail its negative impact on compassion fatigue and burnout. More research is needed into why nurses and organizations do not champion the importance and value of caring work (Chinn &Wheeler,1985; Mitchell, 2017). Also noted is the need for research exploring how to equip nurses to deal with emotional labour burdens. The challenge for nursing is to examine the concept of nurse

resilience in-depth to increase understanding regarding factors that foster resilience or promote its development (Draper-Lowe, 2016).

Patriarchy and Subservience and its Impact on Resilience

Nursing developed within a biomedical and androcentric hospital system. A common theme noted in the literature is that nurses became subservient to physicians who were ruling class members (Bunting & Campbell, 1990). Allen and Smith (2016) stated that patriarchy is a social system in which the male holds power; they govern politics, society, morality, and property and have authority over women and children. The patriarchal dominance and power structure are evident in health, and nursing leadership is not included in health decisions at the local or policy levels (Sundean & Polifroni, 2018).

Nursing exists within a power structure in health that has persisted since nursing first grew out of a need for nurses to work in military hospitals (Eliason, 2017). Nurses gave up their rights to clinical decision-making to military physicians to gain employment in military hospitals during the Crimean and Civil Wars. Nursing began with a subservient and subordinate relationship (Fowler, 2017). The male-dominant hierarchy was transferred to the doctor-nurse connection with society's same male-female authority order (Choperena & Fairman, 2018).

According to Tayray (2009), nursing is a fundamentally gendered institution embodied within a patriarchal healthcare system and culture. Traynor expressed that patriarchy affects and shapes the low position and invisibility of caring work. The perception of caring work as invisible is a repeated theme in the literature (e.g., Attenborough et al., 2019; Mitchell, 2017; Theodosius, 2008).

Nursing education grew out of a hospital system where nursing care was essentially unpaid labour, impacting the value of nurses' work (Bunting & Campbell, 1990). Mitchell (2017)

stated that medical schools were separate from the hospital, and their students had to pay to attend; therefore, medical school had more value, and the physicians were more valued than the nurses.

Well-known Canadian Street nurse and homeless advocate Cathy Crowe (2019) noted that nurses began to develop collective consciousness of their oppression in response to the Grange Commission[1] after the 1980–81 deaths at the Toronto Hospital for Sick Children. This prepared the stage for The Registered Nurses Association of Ontario's adoption of feminism as a central dogma so that nurses would grow to understand the politics of sexism and the patriarchal organizational control of nursing. Crowe stated that historically nursing had been viewed as a womanly art within a healthcare system dominated by a predominantly male medical hierarchy, the traces of which remain today, especially in the structural system that restricts and controls nursing roles.

Nurses are seen as an oppressed and subservient group by many authors in the literature globally (e.g., Eliason, 2017; Fowler, 2017; Tayray, 2009). Leary (2020) explored the nurse's lived experience of oppression and power dynamics in a hospital setting to further examine the impact of subservience and oppression. In this doctoral dissertation, research participants stated that power and the ability to control the work environment resided with groups other than nursing. They noted that an ideal work environment would exemplify shared governance and civility. Friend and Sieloff (2018) studied the topic of oppression and nursing. They came to the same conclusion: they recommended nursing empowerment as the key to freedom from oppression gained through control over the work environment and autonomy as a profession.

[1] The Grange Commission was named after Mr. Justice Samuel Grange who presided over the Royal Commission that investigated the sudden deaths of 43 babies at the Hospital for Sick Children in Toronto. Nurse Susan Nelles was charged, and another nurse was investigated, neither were prosecuted. The cause of the deaths remains unresolved.

In further evidence of the profession's marginalization, Sundean and Polifroni (2016) maintained that fewer than 5% of nurses are voting board members about health policy compared to 20% of physicians. The opportunity to utilize nursing knowledge to support health transformation and social justice is lost. Nurses' voices continue to be unrecognized and unacknowledged for the contributions they could make at the policy level (Crowe, 2019; Jackson, 2020; Sundean & Polifroni, 2018).

Crowe (2019) stated that nurse bureaucrats and doctors manage healthcare; they make decisions about healthcare based on the organization's needs, not necessarily on what is best for patient care. Crowe thought nursing's strength, courage and entrepreneurial spirit had been suppressed by medical domination of the healthcare institution and nursing's obsessions with professionalization to gain legitimacy.

Traynor (2016) expressed that patriarchy affects and shapes the low position and invisibility of caring work. The perception of caring work as invisible is a repeated theme in the literature (e.g., Attenborough et al., 2019; Mitchell, 2017; Theodosius, 2008).

Nursing, Feminism and Voice

There has been a noted complicated and uneasy alliance between nursing and feminism; the reasons for this will be discussed. The history of nursing and feminism will be reviewed, and the advantages of it aligning with feminism to achieve a professional identity and voice will be discussed.

An Uneasy Alliance

There is an acknowledged "uneasy alliance" between feminism and nursing in the literature. Although nursing and feminism have many common philosophical tenets like social justice and equity, nursing has an uneasy alliance with the feminist movement. Stillwell (2019)

noted that nursing as a professional choice was not promoted in the early days of the feminist first wave in the 1970s because women were encouraged to become doctors, not nurses: nursing was seen as a lower-status profession. Nurses who chose the profession as a type of calling were not encouraged to become feminists because they felt that feminism discouraged them from following their calling. Feminism, however, is a practical framework to utilize in nursing to exercise political agency and confront medical patriarchy (McGibbon et al., 2014; Sundean & Polifroni, 2018).

Chinn and Wheeler (1985) contended that the value of a feminist epistemology for nursing holds that the basic assumption of feminism is power dominance and oppression. These authors stated that one must understand women's oppression to comprehend the most ongoing nursing problems. A feminist perspective, these authors posited, would inspire nurses to embrace and applaud the nurses who participated in caring for the wounded in the Crimean and Civil Wars and who later fought for suffrage, birth control, and social injustice.

In both the current day and historically, many courageous nurses have fought for equity, like Mabel Keaton Staupers, who advocated for African American women in the United States Army, and Alex Wubbels, who, in 2017, refused to allow the police to take a blood sample from an unconscious patient (Attenborough et al., 2019). Many nurses who made essential contributions to the feminist movement were not identified as nurses, like Margaret Sanger, who fought for control of the female body (Kane & Thomas, 2000).

From a Canadian perspective, historically influential nurses include Dorothea Palmer, who fought for birth control in the 1930s; Anne Ross, a nursing manager and health advocate; Peggy Anne Walpole, an emergency room nurse who developed a women’s shelter and housing; Marion Dewar, a public health nurse who became mayor of Ottawa. Nurses need to mobilize as a

profession to fight for social justice issues, yet this has not happened: the reason for this lack of mobilization remains unknown (Crowe, 2019).

Welch (2011) argued that a feminist pedagogy in nursing education leads to empowerment because it encourages new narratives that are much needed. This author suggested that focusing on narrative and vibrant learner-centred educational designs would help to uncover nursing voices. Nursing is a dominated and oppressed group (see e.g., Bunting & Campbell, 1990; Chinn & Wheeler, 1985; Eliason, 2017; Fowler, 2017; Mitchell, 2017; Stillwell, 2019; Tayray, 2009), and there is a valuable connection between nursing and the feminist movement because the history of feminist traditions acknowledges that bias exists systemically and it privileges women's voices, issues, and lived experience (Hesse-Biber, 2013).

Nursing knowledge is associated with the medical model of health, which is positivistic, based on cause and effect, and a white middle-class and male health model (Eliason, 2017; Mitchell, 2017). There are many advantages to nursing's alignment with feminism. Eliason noted that feminism addresses the inequalities created by patriarchal institutions and that feminism contributes to the nurse knowledge base, expanding their roles in health care, transformation, and social justice. Nursing has struggled to gain a professional identity (Chinn & Wheeler, 1985). Traynor (2016) characterized nursing as a semi-profession and medicine as an exemplary profession. This idea has lowered the field's status, making it seem that nurses' work is unworthy and second-class.

Feminism and Voice Uncovering Subjugated Knowledge

There are prominent themes in feminist literature, such as acknowledging voice and the goal of feminist research uncovering subjugated knowledge. Feminism acknowledges the victims of oppression with the goal of un-silencing the representatives of the oppressed: feminist

researchers believe that individual voices have been silenced through patriarchal institutions, and they seek to understand women's experiences (Gray et al., 2015; Hesse-Biber, 2013).

Well-known feminist sociologist Dorothy Smith (2000) elucidated the importance of hearing a woman's voice about their experiences from their point of view. This is an integral aspect of Feminist Standpoint theory, where women's life experiences become the starting point for building knowledge (Wigginton & LaFrance, 2019). Harding (1987) noted that, although knowledge should be based on experience, male dominance has ensured that women's experiences differ from men's and that women continue to be oppressed and dominated.

The question of how to promote empowerment and voice in a mostly female-gendered profession in nursing remains problematic. Crowe (2019) noted that power has historically been something administrators and doctors hold within the hospital organization. Crowe also noted that, although many nurses may be activists philosophically, many could be single mothers working part-time or casual jobs. They are afraid that if they speak out to the institution, they will get fewer shifts or be passed over for promotion; this adds to feelings of powerlessness. In Crowe's experience, although perhaps a coincidence, she was consistently passed over for permanent jobs in public health when she became vocal about her advocacy role working with the homeless population in Toronto. Being silent and unknown adds to the profession's lack of visibility and maintains the status quo that places nursing, the largest group in the healthcare sector, as fundamentally invisible (Buresh & Gordon, 2006).

Nurses have been seen to be active and vocal when ethics are challenged, and it is in these instances they become engaged in voice, power, and politics. McMillan and Perron (2020) examined feelings of powerlessness in nursing due to rapid organizational changes that impact

how nurses deliver patient care. These authors stated that, although nurses felt powerless, voiceless, and apolitical, this changed when nurses felt challenged ethically.

Well-known and acknowledged feminist philosopher Lather (1991) advised that, through the questions that feminism posits and the absences that it locates, feminism argues for the centrality of women in shaping our consciousness, skills, and institutions and the redistribution of power and privilege. A feminist framework applied to the context of nursing sets the groundwork for new theory development and legitimizes the nursing profession's ongoing advancement (Sundean & Polifroni, 2016).

Nursing and Learning

Retaining new graduates in nursing is a concern because research suggests that many recent graduates leave the profession within the first few years. Some estimate that 33.5 % of new nursing graduates leave the field within 2 years of graduation (Draper-Lowe, 2016). Many nursing authors found that the focus in nursing has been to graduate nurses with a high level of instrumental knowledge. Now, nursing educators are challenged to produce graduates who can think critically, solve problems and be caring, calling for a blend of the art and science of nursing (Price et al., 2007; Rieger & Shultz, 2014). Rieger et al. (2016) suggested that arts-based pedagogical tools be used in nursing education to help develop a nursing student who has a holistic viewpoint and embodies the art and science of nursing.

Nursing resilience ought to be an essential aspect of nursing education and a topic of concern for the profession. Building resilience is critical for nursing students because there will be positive implications for their resilience as nursing graduates (Hamadeh Kerbage et al., 2021). Resilience in nursing students, however, is a relatively new topic and is not well defined

(Thomas & Revell, 2016). More needs to be understood about how to resilience can be taught in nursing education.

Amsrud et al. (2019) completed a systematic qualitative and thematic literature review on nursing student resilience. They concluded that two themes in the literature seem prevalent in developing nursing student resilience: the importance of nursing education modelling a culture of trustworthiness and the advancement of nursing students' readiness to care. These authors concluded that educators could assist in developing resilience attributes by modelling the skills and traits necessary in their interactions with students, like communication and caring. Student learning in a supportive climate helps develop a caring presence where the student becomes attentive to the patient's needs and looks beyond themselves.

Nursing students experience similar stress-related health issues as registered nurses and have been noted as a high-risk group for low levels of resilience (Ching et al., 2020). The importance of resilience in nursing students has been recognized. Still, more research is needed about how best to achieve this goal, specifically on what affects a student's level of resilience and how this can be enhanced (Thomas & Revell, 2016). Diffley and Duddle (2022) stated, in their systematic review of nursing resilience research, that there is documentation on interventions used in nursing students to foster resilience. These authors noted that there were implications for further study as the result of their literature review on the impact of spirituality and social media use which they said is positively correlated with improved nursing student resilience.

There are many designations of nurses based on the level of nursing education. Registered nurses (RN) can work in various hospital and community settings and typically function as the nurse in charge on shift. Typically, RNs have a 4-year nursing degree, or a 2-year

fast-track nursing degree for those with a bachelor's degree in a non-nursing field. Licensed practical nurses (LPN) typically have an 18-month diploma and have limited duties compared to RNs, and they perform more direct care in some settings than RNs. Nurse Practitioners (NP) have a nursing degree and a master's degree in nursing and have expanded duties to perform medical diagnoses, order tests, and prescribe medications.

The demand for high marks is a complicating factor in a student's acceptance into nursing programs. This is a complicating factor because, under the current conditions, a student who has a call to care will not be accepted into a nursing program unless they also have a high-grade point average.

Across Canada, there are various requirements for admission to nursing programs. Nursing programs like the one at the University of Calgary demand a grade 12 average of 90% (University of Calgary Future Students, 2022). At Dalhousie University, nursing students are encouraged to apply to the program with a 75% average, but a higher average would make their application more competitive (Dalhousie University Future Students, 2022). The students at Dalhousie also complete a personality test called the CASPer test. This test is described as an open-ended situational judgment test meant to test the applicant's suitability for people-centred professions. This shows that some universities are exploring a nursing student's suitability past a sole examination of their grade point average. At the University of British Columbia, they offer only a 20-month Bachelor of Science in Nursing degree and state that students interested must have a 70% grade point average over 48 non-nursing university credits (University of British Columbia, 2022). There are no direct entry programs for high school students. This would mean that nursing students would have more life experience as they enter the nursing program and that the cost of a six-year program could limit access.

Mentorship in Nursing

Hostetter (2012) acknowledged that a contributing factor in novice nurse turnover and attrition rates is their unpreparedness to transition into practice in the difficult and complex conditions within which nurses work. There is a need to change how nurses are educated, but there is less clarity about how to accomplish this. In nursing, positive mentorship has been indicated as vital in developing more tacit skills in nursing, like caring. The support of novice nurses as they transition into nursing practice post-graduate is important. Duffy (2005) proposed the importance of developing caring through experience via a mentor in nursing. Mentorship supports younger nurses by teaching the more tacit skills that are better learned by observation and reflection.

Rauch and Butzlaff (2020) stated that nurse mentorship has long helped transition new graduate nurses to their roles. Still, the mentors often find themselves already spread across conflicting priorities, and mentoring becomes more of a helping role rather than effective mentoring. These authors noted that there is an advantage to using motivational interviewing strategies to help the mentee learn about the best course of action in a more problem-posing way. Nowell et al. (2017) noted that less than 35% of healthcare organizations had developed formal nursing mentorship programs.

Mijares and Radovich (2020) suggested a more effective mentorship program. These authors characterize this as one whereby the protégé would have continued access to their mentor for an extended period even after the initial mentorship period has been completed. These authors looked at a structured, evidence-based mentorship approach instead of informal learning. They felt this model proved more effective in supporting new nursing graduates and improving employee retention and satisfaction but required nursing administration commitment to support

it. Baker-Armstrong (2020) expressed that mentorship plays an integral role in developing resilience and that its benefits cannot be understated.

Resilience in Nursing

Taylor (2019) stated that the experiences of nurses dealing with trauma in their work life are inherent in the caring role; it is usually an intermittent part of the job. Unfortunately, it is often determined that a lack of resilience is due to a deficit in the individual's makeup. Interventions to improve resilience are focused almost entirely on individual responses, characteristics, and interventions. According to Taylor, what needs to be addressed are interventions that explore not only the nurse's ability to remain resilient but also an assessment of the institutional work environment contributing to burnout. This perspective is shared by Suslovic and Lett (2023) who noted that nursing is a fundamentally oppressed group and that resilience "treatment programs" point to individual level interventions in response to systemic contamination. The working conditions and a nurse's ability to remain resilient occur contemporaneously and must be addressed collectively when looking at nursing resilience. Badu et al. (2020) expressed that much of the resiliency research in nursing has focused on costly, time-intensive interventions completed outside work hours and individually focused.

Although individual trauma in nursing can exist, Jackson and Daly (2004) pointed to stressors that are infrequently pointed out and which also contribute to burnout and stress in nurses; these are excessive workloads, lack of supplies, chronic staff shortages, a lack of autonomy and bullying. Jackson noted that nursing is facing a challenge to improve the work environment if nursing is serious about retention. Nursing and healthcare workers, in general, are expected to do more with less, which is taking a toll.

Traynor (2020) was critical about how individual nursing resilience takes the blame for a healthcare system that needs to change in response to an increased complexity that is difficult to work within. Traynor stated that working conditions in healthcare are exploitative and dysfunctional, contributing to resilience tests. Conolly et al. (2022) reiterated this perspective in their narrative review of nurses in the context of the COVID-19 pandemic. These authors stated that it is vital that the institution does not blame nurses for not having ample resilience, particularly within the extreme challenges that nurses faced in the context of the pandemic.

Self-efficacy has been seen as an essential attribute in recent nursing student literature on nursing resilience. Hughes et al. (2021) noted that self-efficacy is the confidence that one can overcome stressors and is key to attaining nursing resilience. These authors examined resilience in nursing student education and suggested that self-efficacy, self-care, self-reflection, and optimism are essential to developing resilience. Badu (2020) noted that, in addition to individual resiliency interventions like self-efficacy and positive thinking, there also needs to be a commitment by the institution to support resiliency, both formal and informal, through leadership and role modelling.

The National Academies of Sciences, Engineering, and Medicine. (2019) has recommended that there needs to be a systems approach toward clinician burnout in healthcare that address high workload, administrative burden, and poorly designed technologies. The WHO (2019) advised that burnout is an issue related to employment conditions, not an individual mental health diagnosis. This is a significant essential step toward looking at the broader system impact on the healthcare workers' resilience and something that bares more research.

Literature exposing the impact of nurse manager behaviours on nursing resilience has been gaining more interest in the literature. Putra et al. (2021) explored nurse manager caring

behaviours using an exploratory approach with a cross-sectional sample of 485 nurses in Indonesia. This study determined that nurse managers' caring behaviours cultivating a positive working environment positively impacted nursing resilience. Cara (2011) asked how nurses can be empowered by nursing management in their work environment. In this paper, the author suggested that nurse managers could improve nurses' caring relationships with their patients through positive and caring leadership. It indicated that nurse managers and administrators do not lose sight of their nursing values in their positions of power and realize that a nursing staff that feels valued will care more for their patients and improve outcomes.

Similarly, Clerico et al. (2013) suggested that a positive relationship existed between patient satisfaction and nurse administrators caring gestures toward their nurses. These authors shared that staff benefits when nursing administrators know and show interest in their team because this impacts their intention to stay.

Raso (2021) stated that a positive working environment with caring and authentic nursing leadership responsible for shared decision-making, collaboration and recognition supports resilience. She says there is a relationship between resilience and the work environment, and nursing resilience will not be improved unless there is a change in the work environment.

Childress (2019) discussed how, as a director of nursing, she supports her staff and their resilience, and she highlights how important nurse leadership support is for nurses and what that support looks like.

> "I know that the nurses graduating this year have many different challenges than I had and will need different skills, but at the end of the day, it is about supporting them with appropriate workloads and processes, promoting a civil and caring culture and providing a strong manager to keep the focus on our patients." (p.672).

Self-Care and Nursing Resilience

Nurse self-care is a topic in the literature that has been gaining more interest in recent years, and it bears discussion in this literature review. Maté (2021) suggested that caregivers must show more compassion for themselves because this group rarely looks after themselves. He suggested that he disagrees with the concept of compassion fatigue; he believes that all humans are compassionate; we become tired of not showing our emotions. This does share similarities with Hochschild's (1983;2012) theory on emotional labour.

According to Andrews et al. (2020), nurses' experiences with self-care have been linked to increasing nursing resilience. An inability to practice self-care was linked to a failure to be caring and compassionate and negatively impacted the nurse's well-being. These authors stated that nurses need permission to adopt self-care strategies through nursing education and guidance from their managers, organizations, and the nursing culture.

On institutional support, Wei et al. (2019) expressed that self-care is crucial and must be encouraged in nurses by their nurse leaders. These authors state that nurse leaders must create an environment that supports nurse self-care to evaluate their needs and help them recharge. Additionally, self-care is usually not adopted until a struggle with resilience is noted.

In the shadow of the COVID-19 pandemic, implications for adopting self-care strategies in nursing educational curricula have been suggested for fostering resilience so that students are best prepared for the realities of nursing practice (Mills et al., 2021).

According to the American Nursing Association (2016), many nurses have poorer health than the average American. Backer and Ulibarri (2021) wondered why nurses do not want to instinctively practise self-care and put the metaphorical oxygen mask onto themselves first.

Nilsson (2022) suggested that good examples of self-care strategies included meditative walking, prayer, and the mindfulness practice of body scanning, which positively enhanced nurse resilience. This author recommends that it is essential, from a self-care perspective, that nurses set aside time daily for self-care strategies to deal with the stressors that nursing work entails.

Nursing during the COVID-19 Pandemic

Nursing during the COVID-19 pandemic has caused great stress and fatigue for nurses who had to work long hours amidst the threat of contracting the virus at work. Clancy et al. (2020) stated that many post-pandemic mental health conditions would become evident in nurses and manifest in disorders like post-traumatic stress disorder (PTSD) and chronic and acute stress. These authors recommended that sharing feelings with colleagues has been shown to reduce stress and promote a team atmosphere. They also stated that bonds among team members matter in supporting ongoing resilience.

The importance of feeling like a team member was a theme that came out of a qualitative study on nursing students' experiences working on the frontline of the COVID-19 pandemic. Vázquez-Calatayud et al. (2022) studied nursing students' experiences in the context of hospital wards in Spain. Nursing students shared how a sense of belonging impacted their abilities to cope and feel comfortable in their working environment. These authors suggested more qualitative research on nurses' experiences in other health contexts during the pandemic to explore management and educational strategies that supported nurses dealing with this public health crisis.

Ashley et al. (2021) examined public health nurses working in Australia with semi-structured interviews and a mixed methods approach. The importance that nurses placed on feeling valued by the institution was elucidated; participants stated that feeling valued by their

management helped with their psychological well-being during the pandemic. This research also highlighted the importance of being involved in decision-making in the workplace and that this needed to be addressed to increase staff satisfaction and retention. These authors acknowledged that there was little research on nurses who worked in public health during the pandemic, even though their work contributed significantly to the fight against COVID-19 and public safety. Jo et al. (2021) added to the research on organizational support and resilience. They concluded that there were positive benefits to administrative support and nurse involvement in policy development. Their study involved cross-sectional analysis, and they concluded that more qualitative research was needed into the experiences of nurses coping during the COVID-19 pandemic.

Essential programs and services were paused while nursing staff were redeployed to work in other areas of healthcare to meet the demands of COVID-19. Nurses were redeployed to help manage the public health programs, the complexity of the gravely ill COVID-19 patient, and the public health preventative programs. Jackson (2022) noted that more research needs to be dedicated to the outcomes of the patients in the paused programs and the nurses who were redeployed, as little is understood about how this has impacted them.

Nurses know and understand death, but death can also represent failure. The unprecedented mortality that the pandemic caused in patients who frequently had to die without family support has led to even more distress and exhaustion in an occupation already struggling with resilience (Jackson, 2022). Nursing resilience is an even more concerning topic amid post-pandemic healthcare, a shortage of staff and the relative exhaustion of the team that remains.

Chapter 4 Methodology and Theoretical Underpinnings

The methodology I utilized in this research is narrative inquiry set within the broader base of the arts-based research paradigm. With this research, it is essential that the lens with which I viewed this exploration be seen from the perspective of and with keen attention to power and control within the healthcare institution. This research, therefore, is underpinned by the feminist theoretical framework, which guided the way that I approached the research participants, the questions that I asked them and the view with which I considered what they shared. The following will outline the arts-based research paradigm and narrative inquiry methodology and discuss how I incorporated arts-based research and narrative inquiry with a feminist lens to give voice to the stories of nurses' resilience.

Arts-Based Research

Leavy (2018) defined arts-based research as the intersection between art and science and described it as a transdisciplinary approach to knowledge building that incorporates the arts within the research context. From an epistemological viewpoint, Leavy, like Eisner (2008) and Cole and Knowles (2008), saw art as a way of knowing. Leavy (2018) saw arts-based research as creating and conveying meaning and argued that there is a debate amongst the research community about whether it is a methodological field within the qualitative research paradigm or its own paradigm. Leavy believed that arts-based research is a broad umbrella term encompassing all artistic approaches to research; she felt it was its own paradigm. Leavy and Harris (2019) stated that arts-based research has developed into its own paradigm over the last three decades. These authors noted that arts-based research could include writing, drama, dance, visual arts, film, and other artistic mediums.

Cranton (2006) thought visual art, music, or literature could promote transformative learning. Themes noted in the literature on the use of art in research include its capacity to make the invisible visible, to explain without words, to express visually (Jarvis & Gouthro, 2015), its ability to form new knowledge (Eisner, 2008), and the potential to represent visually multiple realities (Leavy, 2018). In a 2015 research study, I studied nurses' understanding of the social determinants of health by nurses. In this study, the research participants expressed that, through art, a deeper understanding of the social determinants of health was achieved and, in some, an almost transformational way of knowing (Flegg, 2020).

Elliot Eisner (2008) argued that the arts are more than merely ornamental representations; the arts have a significant role in human understanding and are, in fact, a form of knowledge. To Eisner, the arts reveal a world you may not have noticed, and they can generate feelings of empathy and provide a way of understanding and expressing experience. Eisner was one of the first in education to use art as a vehicle for multiple ways of knowing; he stated that art could be used to improve the understanding of the human condition, making more expressive realities that may otherwise remain unknown. Eisner was among the first to use the term arts-based research (Leavy, 2014). English and Irving (2016) noted that art and artistic ways of knowing have always been vital to education, learning and activism.

Barone and Eisner (2012) stated that arts-based research aims not to come to any definitive answers but to encourage conversation and prompt new inquiries. Leavy (2018) indicated that there could be value added from the deep level of reflection in the process of making art. Still, there can also be carryover effects for the viewer of the art, which can be transformational.

Ardra Cole and Gary Knowles coined the term arts-informed research as an alternative to qualitative research in the late 1990s (Cole & Knowles, 2008). These arts-informed research scholars pointed out the essential qualities that define the purpose of arts-informed research: a form of qualitative research influenced by but not based on the arts. Its central goal is to heighten understanding of the lived experience. Arts-informed research includes a holistic approach to understanding processes, emotions, and the participant's subjectivities. Cole and Knowles shared Eisner's (2008) view that knowledge could be advanced through the arts in research. Arts-informed research has a cerebral and moral purpose as an opportunity to reflect, engage and reveal the central goal to advance knowledge, not produce art.

Researchers seek to understand subjective reality in all qualitative methods (Beddes, 2017) and adapt the creative arts tools to weave theory and practice to address social research questions (Hesse-Biber & Leavy, 2011). Scholars have suggested that the role of the arts in articulating the professional position can be more visible through artwork (Jarvis & Gouthro, 2016). Art can be used as a research tool to uncover hidden and unexpressed meaning in educational contexts like nursing, adult education, and feminism (see, e.g., Butterwick & Roy, 2018; English & Irving, 2015; Rieger et al., 2013).

Archibald et al. (2016) described two types of education achieved through art: knowing about art and knowing through art, which is achieved by learning from the process of making art. Rieger et al. (2020) researched an arts-based pedagogy in nursing education in Canada, and they found that art was a catalyst for learning by nursing students. They noted that the arts allowed for connection to and expression of feelings that were difficult to uncover. Obara et al. (2021) suggested that an arts-based pedagogy in nursing enhances learner engagement, critical thinking, and group association. These authors stressed that an arts-based pedagogy connects the personal

with aesthetic ways of knowing and may help student nurses to develop caring relationships with patients.

Mokel (2017) described an educational departure using an art-based pedagogy in a course on ethical issues in advanced practice nursing. Nurses in this study expressed their ideas about feminism and voice in a creative and non-threatening artistic mode of inquiry. Nurses articulated their feelings about feminism and women's health in a non-threatening and creative way, achieved by viewing works of art in a gallery setting.

Ang et al. (2019) used an arts-based methodology to research the resilience of two staff nurses and six managers in an academic hospital in Singapore. The research participants used photovoice to document images of resilience shared with the group to promote dialogue and discussion about nursing resilience. The participant who took the photo described it to the group, and then group members shared what resonated with them upon viewing the image. These authors concluded that psychological support is needed to support resilience in the healthcare setting. They concluded that the factors that promote resilience are vital to maintaining a sustainable nursing workforce.

Arts-Based Research and Narrative Inquiry

Collage was first expressed in fine art using collected materials from Picasso's everyday life in 1912 (Butler-Kisber, 2018). Artistic collage is non-threatening, using easy-to-access materials. Artistic expressions created are not judged on their aesthetic appeal but on the research participant's reflections and insights resulting from the creative process. Collage can integrate words and text in the art creation; thus, it utilizes visual and verbal dimensions. It can also interpret, via a graphical mode, unconscious or challenging experiences that may be impossible to express through other inquiry methods (Scotti & Chilton, 2018).

Collage is used in the inquiry process to express the subjective experience, encourage dialogue and storytelling amongst participants, or as an instrument for reflexivity (Butler-Kisber, 2018). Collage in this research study helps demonstrate and understand resiliency and emotional labour stories in public health nurses and visually express their stories of nursing resilience. Each collage element synthesizes a previous world and a new one onto which it is pasted (Brockelman, 2001). Butler-Kisber (2018) described that the artist works from the heart to her head by creating a collage piece, seeking out the collage pieces to represent feelings and experiences. Using the arts helps to share nursing resilience stories from the "knowers" perspective. The collages represent the past and present thoughts of the research participants in this study and speak with two voices, the past and the present.

There are examples of the mutual benefit of using art and narrative inquiry in the nursing literature. Narrative inquiry complements other research methodologies, such as arts-based research (Butler-Kisber, 2018). Frost (2019) explored the use of narrative inquiry and arts-based research with student nurses to debrief about their experiences in clinical. They chose images to express their thoughts and feelings and a written narrative of their experience. There was consensus among the research participants that viewing an image was an important starting point. It facilitated a process where they could focus on their feelings, thoughts and emotions and then begin the debriefing process. The combination of the nurses' narratives during the pandemic in this research will integrate their verbal recounts and the expression of their stories through artistic collage.

Narrative inquiry is a methodology for studying experience in which the unit of analysis is the story (Clandinin, 2013). Narrative inquiry is a way of understanding experience; in Connelly and Clandinin's (1990) approach to narrative inquiry, a person's recent experience is

viewed as a direct product of their previous ones. Connelly and Clandinin first used narrative inquiry in educational research, noting that it grew from Dewey's (1938) notion that life is education. Connelly and Clandinin aligned themselves with Deweyan pragmatics and believed that experience results from an ongoing interplay between the past and the present, impacting the future (Butler-Kisber, 2018). Dewey's theory of experience underpins narrative inquiry and underscores the two criteria of experience defined by Dewey, interaction and continuity enacted in situations (Clandinin, 2013).

Narrative inquiry is a collaboration between the researcher and the participants; it takes place in a series of sites over time and involves living, telling, and re-telling stories (Clandinin & Connelly, 2000). Within narrative inquiry, there is the underlying belief that an individual's stories are linked to other stories, which are themselves linked to other stories in an unending progression of meaning-making, which is fluid and ever-changing (Butler-Kisber, 2018; Clandinin, 2013). Narrative stories bring silenced voices to the forefront and question prominent views of history, culture, and society (Butler-Kisber, 2018).

Narrative inquiry revolves around an interest in life experiences as told by those who have lived them (Chase, 2011). Narrative inquiry studies how humans experience the world (Connelly & Clandinin, 1990) and focus on stories conveyed by the teller (Goodson & Gill, 2011). Epistemologically, narrative inquiry sees the nature of knowledge as created, understood, and experienced by individuals or groups in their interactions with other people and the broader social context (Wang, 2017).

Narrative inquiry underlines the presence of multiple realities and interpretations of experience, all of which are plausible (Butler-Kisber, 2018). Narrative inquiry recognizes that lives are socially constructed and transactional. The narrative inquirer studies an individual's

experience in the world and, through the study, investigates ways to transform that experience for themselves and others (Clandinin & Rosiek, 2020). The researcher's role is to facilitate and promote the research participant's voice through the co-construction of meaning, whose origins are created by the relationship between the researcher and the research participant (Goodson & Gill, 2011).

A basic assumption of narrative inquiry is the importance of reflexivity, including the researcher's understanding of their positionality and its contribution to the inquiry process (Butler-Kisber, 2018). An essential part of this is achieved through field notes, personal journals, and note reflections by the researcher, which can be reflected upon during the research.

Clandinin (2013) stated that a researcher's autobiographical narrative is the starting point for the inquiry. This process allows the researcher to begin to shape the research puzzle and develop the personal, practical, and social justifications for the research. As narrative inquirers, we are in the circumstance under study over time. As the inquiry proceeds, we are also making and re-making our lives amid our inquiry. It is crucial to discern the justifications for the study to formulate a response to the "so what" and who cares" questions that might be posed.

Narrative inquiry places the utmost importance on stories of experience. From a constructivist standpoint, people live storied lives, which is where narrative researchers consistently return. Connelly and Clandinin (2006) noted that people's past experiences shape their stories, and, in turn, their experiences shape their future. Narrative inquiry is one way to understand human experience because humans utilize stories to understand their lives.

The narrative inquirer seeks to continually clarify observations with the research participants in a transactional way. This critical ontological consideration, which answers the

question of what can be known, underscores the fundamentally collaborative nature of narrative inquiry (Clandinin, 2013)

Clandinin (2013) stated that narrative inquiry considers the stories people tell and the social, cultural, and institutional contexts within which people's narratives are shaped. Clandinin noted that narrative inquiry captures experience within a three-dimensional narrative conception: temporality, place, and sociality. The focus is not only on the individual's experience but also on the social, cultural, and institutional narratives within each individual's experiences that are derived, shaped, expressed and enacted (Clandinin, 2019). Narrative inquirers attend to personal and social places, seeing lives and experiences in their derived context. Narrative inquirers cannot remove themselves from their research. In narrative inquiry, because it is a relational methodology, the "field" must be where two human beings will come together in an ongoing relational inquiry space. The researcher will recognize negotiations within this space (Butler-Kisber, 2018; Clandinin, 2013), and the conversations created give voice to stories produced by both the researcher and participant to be heard and composed (Clandinin & Caine, 2013). According to Clandinin, narrative inquiry begins and ends with a deep respect for ordinary lived experiences. In this research, narrative inquiry was critical to sharing nursing resilience stories in this research because it examined the social, cultural, and institutional narratives within each nurse's individual experiences.

Arts-Based Research and Feminism

There are examples in the literature where arts-based research was utilized within the feminist theoretical framework. Butterwick and Roy (2018) used the arts to inform a study of marginalized women in a community arts project. These authors found that the arts are an

invitation to listen to experiences and voices often ignored and provide an opportunity to listen to often unheard voices.

According to Gray et al. (2015), arts-based research approaches align with feminist analysis because both disrupt dominant social discourses that marginalize and silence women. Feminist research is about understanding women's experiences, and its underlying objective is improving women's lives and equalizing power inequities. There is a strong relationship between the goals of feminist and arts-based research: uncovering subjugated voice.

Lather (1991) stated that the practice of doing feminist research puts the social construction of gender at the centre of the inquiry. Arts-based research methods have the inherent ability to uncover subjugated knowledge and reveal thoughts and feelings that may not reveal themselves. Leavy and Harris (2019) stated that feminist researchers have been turning to the arts for decades because it pushes people to consider other perspectives, promotes social and self-reflection and reveals multiple subjective realities.

Reflexivity

Reflexivity in feminist research predicates that the researcher does not merely gather and hold preference over the information collected but instead passes information and power to research participants in a spirit of co-construction (Hesse-Biber, 2013; Harris, 2018). Being reflexive is very much a part of engaging in narrative inquiry (Clandinin et al., 2016). In narrative inquiry, it is integral that the researcher enters into the lived experience and perspective of the research participant. Butler-Kisber (2018) stated that in narrative inquiry, the researcher stands in the participant's shoes and their emotional bodies to feel what they feel as well as one can (Butler-Kisber, 2018).

Reflexivity in the research process is also an essential aspect of arts-based research. As McNiff (2008) described, using images under the right conditions can help create transparency and introduce reflexivity into the research design. Arts-based research can bring the researcher into the centre of the study but not overwhelm the participant. Weber (2008) noted that using images could encourage the researcher to step back. It could inspire them to look at themselves through a different lens, increasing the likelihood that they will better understand their own subjectivity and join the intersubjective space between research and subject.

Green et al. (2022) noted that through creativity, we could be brought into contact with our own world and way of knowing and into the intersubjective space that we share with others and the world around us. Reflexivity helps us as researchers monitor the intersubjective space within the research. It is valuable because it points out that the researcher is a part of the investigational world and that the individuals under study are the subjects, not the objects (Lumsden, 2019). Archibald et al. (2016) explored the contributions made using art, and they concluded that arts use added to regular research communication, opened dialogue spaces, and facilitated education, dissemination, and reflexivity.

Butler-Kisber (2018) noted that research journals serve as essential information sites as the analysis will continue in an ongoing and unfolding process. Reflexivity is critical because of my insider status with the group I am studying and to respect potential power over the research participants. As a researcher, I paid careful attention to the reflexivity process and approached it with an acknowledgment of my insider status. Through my research journal, I reflected on my research as the research puzzle unfolded.

Research Design

The following will describe how the research participants were recruited and my inclusion criteria for selection. Steps were taken to ensure that this research has followed the recommendations distinctive to narrative and arts-based inquiry and the practice of feminist research.

Research Participants

This research study focused on nurses working in public health who were redeployed from their public health nursing roles in the community during the COVID-19 pandemic to testing centres and immunization clinics. Usually, the test centres were drive-through clinics which began in March 2020. These nurses worked outside in the testing centres standing on their feet on pavement in parking lots for their 8-hour shifts, often working overtime to complete the demand for testing.

An in-depth understanding of phenomena typically involves a small number of research participants; I invited four nurses to participate, which allowed me to obtain depth, detailed and multifaceted descriptions of their resilience stories. The study participants were registered nurses, female; three worked full time; the fourth worked four days a week plus casual hours on a second unit. They all had at least five years of nursing experience, worked within the COVID-19 pandemic context in public health, and self-identified as resilient and feminist.

The inclusion criteria were:

1) Research participants were registered nurses with recent experience equal to or greater than five years.
2) The research participants were female and worked full-time.
3) Research participants worked in a public health setting for not fewer than two years.

4) Research participants self-identified as resilient within the field of nursing.
5) Research participants identified as feminists.
6) Research participants met the above criteria and were willing to commit to one-on-one interviews with a focus on conversations, research journals, and a group arts-based collage creation and discussion.

Recruitment of Participants

This research study explored resilient nurses' stories underpinned by the feminist theoretical framework, putting feminism at the centre of the investigation. Feminist research views research participants as people who have the right to know the nature of the inquiry, the risks and benefits of participation, and voluntarily choose whether to participate (Leavy & Harris, 2019). I included an invitation recruitment letter and an informed consent letter that described the purpose, procedures, and outcomes. The participant's rights, demographic information, interview questions, and consent forms are attached in Appendix A–D.

Once I obtained ethics approval from Mount Saint Vincent University in September 2021, I recruited research participants from my professional network. I asked for interested participants and their recommendations for other nurses they knew who might be interested. Once a research participant had expressed interest, I sent a letter of invitation, a participant consent form, and a participant background survey. None of the research participants chose to withdraw from the study, although they knew it was their right to do so. I did not receive more volunteers than were required to complete the study. I obtained consent to obtain digital images of the artistic collages created and disseminate research results. Research participants had a final sign-off for using direct quotes in the final research texts.

Data Collection

The following outlines the data collection methods through artistic collage and artist statements, one-on-one interviews which focused on conversations, reflective journals, observations, reflections, and field notes collected.

Methods of Data Collection

Data were collected from the research participants' collage creations, an artist statement, one-on-one conversations, observations, reflections, my reflexive journal and field notes. Research questions were open-ended to understand research participants' narratives and stories better. This questioning compels the researcher to sustain a prolonged, trusting interaction with research participants (Butler-Kisber, 2018). The conversations were digitally recorded and transcribed; a transcriber was not required as I utilized the Microsoft Teams transcribed notes and recorded meeting videos for review.

I have lived the inquiry alongside the research participants as a narrative inquirer. This narrative inquiry took place in several stages. The first stage was a group art-based collage session. Individuals created an artistic collage and artist statement about their nursing resilience stories. The group session held on Microsoft Teams encouraged group discussion about stories of resilience during the COVID-19 pandemic. I did not create a collage of my own as I was immersed in the research participants' conversations. I created a reflexive painting in the months following the group arts-based collage session to work through my thoughts and emotions as I became immersed in the stories the research participants shared.

The second stage was individual one-on-one conversations after the online group meeting. I discussed these elements of this research at the outset so that research participants could make an informed decision regarding their participation. To gain entry into the inquiry

space, it was vital for me to share my own story of resilience; by doing so, the research participants felt more comfortable sharing their experiences about the topic.

Critical to a narrative inquiry is that the nature of the research study is shared with research participants before the start of the investigations, all particulars of the study, including the duration, activities, and the time needed (Wang & Geale, 2015). As such, the research participants understood the nature of the inquiry and all the relevant details described in the attached Letter of Invitation (Appendix A).

Setting

Ideally, this research study would have been held in a group setting that allowed in-person group discussion. Due to evolving COVID-19 restrictions, the group collage creation and one-on-one conversations were held online between January 2022–June 2022. Research participants were supplied with Microsoft Teams meeting codes and waiting rooms to strengthen security. Participants were provided with art materials for the collage creation and worked on their collage simultaneously with other participants; this encouraged group discussion and sharing. The online meeting format was vital for maintaining the group participant's safety from COVID-19 exposure and upholding public health guidelines and in-person meeting restrictions.

Group-Based Collage Creation

Collage has been recognized as being non-threatening and using easy-to-access materials. It also has the advantage of being accessible to everyone, and even the non-artistic participant is not judged by aesthetic appeal but by the participants' reflections of it. Artistic expression can also interpret unconscious or challenging experiences that may be impossible to demonstrate through other methods (Scotti & Chilton, 2018). Artistic collage helped to express stories of resiliency in public health nurses who worked during the COVID-19 pandemic. I chose this type

of creative expression because it encouraged conversations about nursing resilience and was a mode to share each participant's stories.

Participants had access to various materials such as multiple recycled papers, newsprint, glue, paint, brushes, markers, and an artist's canvas to create their collage in the group-based individual collage creation. Participants chose what materials they wanted, and some decided to use their own collected materials. Participants enjoyed art as a strategy for expression and the forum for discussion about their nursing resilience stories that the collage creation promoted.

Research participants were asked to describe their stories of nursing resilience visually. The arts-based session took approximately 90 minutes; once the individual participant collages were complete, I asked the study participants to create an artist statement and ask them: What would you like to say about your collage? Digital images of the collages were shared with the group and discussed at the second group meeting to analyze each collage collaboratively.

Participants were asked to record their thoughts about their collage in a reflective journal, but this could not be done due to conflicting priorities. Participants graciously gave their time for this research, and COVID-19 was still prevalent in their daily work; I could not ask more from them than they had already enthusiastically given to this research. The art created and shared will not be for financial gain and will remain the research participant's property, except for the digital images discussed and shared in this dissertation in Chapter 5 and subsequent publications.

The group interview provides tremendous potential for astute probing and a shared educative encounter (Lather, 1991). For instance, the arts-based session collected various visual and narrative stories of group participants' resilience stories. Graphic images occupy an elevated place in memory (Leavy, 2018) and help to support it, so it was essential to leverage this during the group-based individual collage creation. The collage inspired reflection, thinking, expression,

and debate in this research study. Arts-based activities can produce affective responses prompting reflection and dialogue (Lapum et al., 2016).

In-Depth One-On-One Conversations

The second stage of this research study included one-on-one conversations with the research participants. Feminist research design is concerned with how the research participants are interviewed to minimize power in the relationship between the researcher and research participants. Feminist researchers strive to see the world from each "knower's" perspective, acknowledging that experiences are not identical but socially located (Pitre et al., 2013).

Research participants in feminist-narrative inquiries are often encouraged to actively develop the research, exploring subjective meanings and experiences that have been ignored in previous research (Fraser & McDougall, 2017). In this research, research participants were excited to contribute to resilience research and give voice to their personal resilience stories.

The one-on-one conversations focused on sharing resilience and emotional labour stories using open-ended and conversational interviewing methods. I only utilized structured interview questions to uncover demographic data from the research participants. See Appendix C. This information must not identify the research participants (Canadian Institutes of Health Research Natural Sciences and Engineering Research Council of Canada Social Sciences and Humanities Research Council, 2018) and this was strictly followed.

After the initial conversation with the research participants, I negotiated further conversations with the research participants as needed. One-on-one conversations were recorded, and the data were stored in a safe place to maintain the confidentiality of the research participants. Conversation transcripts were saved in a private, removable computer file and kept in a locked space when not in use.

I was interested in illuminating nursing resilience stories and providing a space and place for the research participants to do so. I was mindful of the fluid boundaries of the narrative approach. I left open the developing course of the one-on-one conversations to allow it to develop in a natural and unscripted way. Space was created where conversations could be created and heard, as recommended by Clandinin (2013). [2] The commitment to the relationships developed in this narrative inquiry allowed me to re-compose and negotiate the stories heard; as a researcher, I went where the participants took me with their stories. The stories shared from this research relationship are essential to add to the literature and knowledge on nursing resilience.

Researcher's Observations

During the group-based individual collage creation and one-on-one conversations, I took some notes on paper in addition to audio and video recording. Additionally, I kept a reflexive journal about my experiences and thoughts after our meetings to allow me time and space to remove myself from the stories shared. I found this particularly important because as I re-read this journal, I looked more openly and reflectively at my bias as a part of the research and as an insider. I realized that I had experienced many of the same things that the research participants experienced in our work during the pandemic. That made the review of my observations even more critical.

I reviewed the videos from the group and one-on-one meetings and meeting transcripts several times as I began to think about the resilience stories and developed field, interim and final research texts. I was grateful for this recorded medium as I could more astutely examine

[2] Given the circumstance of the COVID-19 pandemic, in-person meetings were not allowed due to public-health restrictions about in-person meetings. Even though it was not possible to meet with participants in person, our virtual meetings became relational spaces of comfort and connection for the sharing of stories.

body language and emotion while the stories were told. Although the use of video recording was dictated by COVID-19 restrictions that excluded meeting in person, I feel it enhanced my ability to reflect upon what I saw and heard during our conversations held together.

Data Security and Handling

All data were kept in a safe, locked area; when analyzed, the data were saved on a private electronic file. Access was only available to me as the researcher. Transcription was recorded on Microsoft Teams. Transcriptions will be destroyed when no longer needed for this dissertation, as declared in the ethics clearance.

Data Analysis

One of the most challenging aspects of narrative inquiry is that the same experience can produce a different narrative account. There is no absolute truth but multiple realities (Butler-Kisber, 2018). The narrative inquirer is not a researcher looking in from the outside; the inquirer comes in and is a part of the experience. As Clandinin (2013) described, the researcher becomes a part of the living, telling, re-telling, and re-living of experiences.

The individual collages created by each research participant provided visual information about the research participants' stories of resilience. As researcher and participant, we continuously negotiated the meaning of the stories by performing validation checks throughout the collection and analysis (Wang & Geale, 2015). This step was vital to this narrative inquiry and was achieved through communication with the research participants. Research participants read their stories in the spirit of co-composition and were given a chance to clarify and make changes as they saw necessary. This allowed study participants to provide feedback and clarify comments. Only one participant wanted one of her stories clarified in one section. Although

comments or information the research participants felt they did not wish to be made public could be removed, none of the research participants wanted to have any of their stories redacted.

Another added source of information about nursing resilience was the written texts in the form of artist statements shared by the research participants, accompanying the participants' artistic collage creations. Artist statements were additional text to add to the visual information gathered from the collages and were important as they added deep and descriptive meaning.

I analyzed the field texts utilizing narrative inquiry approaches described by Clandinin (2013) and Butler-Kisber (2018), paying particular attention to what sets narrative analysis apart from other qualitative studies. The field texts produced during the group-based collage creation and one-on-one conversations were woven into interim texts. With input from research participants in the spirit of co-creation, as Connelly and Clandinin (1990) envisioned, interim texts were then used to create research texts. The texts created were not pulled apart from the whole to be analyzed. Instead, the research texts were woven together, like one would weave threads to develop word images of the participants' experiences and stories. The final creation is a holistic picture of shared knowledge; analysis is iterative, fluid, and ongoing (Butler-Kisber, 2018). Haydon et al. (2018) describe emplotment as merging field texts and multiple dialogues into one story. In this research study, it was essential to pay considerable attention to the stories of resilience that nurses shared and respect each story as they were woven together.

A woven textual collage was created as a visual expression of the resonant threads realized from the narrative stories shared. This collage represented areas where the research participant's stories overlapped with each other. The process of creating this collage created a time and space for me to think about the stories shared and express them visually.

Ethical Considerations

In the following sections, I review the ethical considerations I contemplated before undertaking this research. I was cognizant of informed consent, confidentiality, and relational ethics in narrative inquiry, and I expressed these in the following sections.

Relational Ethics in Narrative Inquiry and Feminism

In narrative inquiry, particular attention is paid to thinking narratively about people's stories, which informs the research in an ongoing research relationship and a commitment to caring. This inquiry type suits this study on nursing resilience because caring relationships speak to a nurse's daily work. In narrative inquiry, these commitments move beyond research puzzles to long-term obligations and ethical care questions (Clandinin et al., 2016). In feminist research, ethics of care and responsibility are understood, ensuring that power differentials are attended to while conducting research (Gray et al., 2015).

Ethical principles guide the pursuit of knowledge through research and protect research participants from harm to build public confidence and trust (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2018). Additionally, informed consent, freedom from deception, privacy, confidentiality, and accuracy are benchmarks for the researcher (Christians, 2011). In this research study, I ensured that informed consent was achieved from research participants without physical or mental coercion while utilizing the principle of freedom from deception. The research study was represented honestly to the research participants. Also, because this research aligned with feminist research practices and ethics, I utilized process consent (Oleson, 2011), which involved consistently checking for ongoing consent. Research participants' names were replaced with a pseudonym to protect their privacy, and I will not share

who participated in the study with anyone outside the study. All data were represented accurately to reflect best the data collected, and research participants had final sign-off for quotations used.

Feminist researchers are also concerned about anti-oppressive practices. Special consideration must be given to potential power imbalances that could harm the research participant (Canadian Institutes of Health Research et al., 2018). Critical aspects of ethical practice in feminist research include doing no harm, practicing confidentiality, using informed consent, avoiding disclosure, minimizing the researcher's power over the participant, ensuring respect for human dignity, and attaining ethics approval. In this research, I was cognizant of and reflected on these values in collecting data and in my relationships with the research participants.

Ethical issues can arise when the feminist researcher is involved in a research project. As a researcher, I know that my belief system may not align with study participants, and sometimes there may be incongruencies. I minimized the effect of this through careful reflexivity.

Benefits and Risks of Participating

The participants may benefit from telling their stories and may not have taken the opportunity to tell their stories of resilience. So, there is a potential direct benefit for them. A second noted benefit of participation is their contribution to the understanding, knowledge, and education about nursing resilience. Also, possible use for the participants may include their involvement in a group with a shared experience. As a part of a group discussing nursing resilience, there may be thoughts and feelings uncovered by the conversations shared and the artistic collage's creation. The benefits of collaborative research were noted by Cole (2006), who concluded that they are experienced by both the researcher and the participant in the research. Cole noted that the advantage of this approach is that the experiences are informed by context and thus describe the phenomenon under question more accurately.

The Concern for Welfare principle is that research is designed and conducted to protect participants from unnecessary harm and avoidable risks (Canadian Institutes of Health Research et al., 2018). There was minimal risk to participating in this research study. I was conscious that a potential threat to the research participants might be linked to uncovering painful experiences from their resilience stories. It was a potential for which I had planned. I made the Alberta Health Services employee and family access line available, a service covered by the employer if needed to access mental health services. I frequently checked in with research participants about how they were feeling emotionally and addressed any issues as they occurred.

Protection of Human Subjects

Respect for and protection of privacy for human subjects is an internationally accepted norm and ethical standard (Canadian Institutes of Health Research et al., 2018). To honour this principle, the study's nature was explained to research participants at the beginning of the study. I reviewed this arts-based and narrative inquiry research plan and asked them, once they were ready, to sign the consent form. The research participants were aware of and agreed to record and transcribe the meetings.

Chapter 5 Narratives

Organization of the Findings

In the following, I will share the research participants' stories of nursing resilience. The research participants ranged in age from 47–58 years old, had worked in public health for 10–33 years, were all women and identified as feminists. Though we started talking about nursing resilience, it moved to more discussion about their personal and family lives, work lives, connections to nursing and caring, and past, present, and future. The story is essential to this narrative inquiry as I developed relationships with the research participants. This is at the heart of narrative inquiry; as researchers, we become part of the participants' lives, and they are a part of ours (Clandinin, 2019). The research participants' stories comprised the research landscape.

I was mindful that, in sharing these stories, I shared them in the way they were presented to me. I honoured my commitment to my relational responsibilities and to sharing the stories that we had co-composed. I was aware that I experienced their stories through the lens of my own life experience as a nurse who worked in a healthcare institution and as a human impacted by my own experiences. Ultimately, I have sought to limit this by sharing the narrative stories I wrote with the participants as I came alongside them, and they told their stories.

My hope in sharing these stories of nursing resilience is that the details of their journeys will help add to understanding and knowledge about it, notably from a woman’s point of view. This has been something that I continued to reflect on and is shared in this excerpt from my reflexive journal:

This study became an inquiry into their experiences, my experiences and our experiences.

The stories that follow represent the stories of the research participants presented in sections; the names of the research participants were replaced with pseudonyms to maintain their

anonymity. Block quotes of their narrative stories are italicized and written as the research participants shared them. It was essential in this research to give voice to the participant's stories; as much as possible, direct quotes are shared in their entirety. After sharing each nurse's story, I share the resonant threads of this narrative inquiry, where the stories of the research participants overlapped; these will be presented in Chapter 6.

Christine's Story

I met Christine online during the first group meeting when the participants in the research study created their artistic collages. I recruited her through snowball sampling; I recall feelings of hope as I sent her the invitation via email. With COVID-19 protocols in place for our first group meeting, I worried about whether I would feel disconnected from meeting the participants in person. I hoped the online forum would be an effective way to begin our story in this research.

Christine and I had crossed paths in our nursing careers, had similar career trajectories, and graduated around the same time. I recall feeling very appreciative that she was willing to take the time to participate in this research study. Her response to my request was almost instantaneous. I remember her concerns about doing an art project; she said, "I am no artist," but she was willing to try because she saw the topic of nursing resilience as very important.

Christine spoke warmly about her nuclear and extended family; I could tell she loved her family members and often spoke warmly about her mother and daughter. Christine missed her mother, whom she cared for before her death 10 years ago. It was clear that, although her mother is no longer alive, she and other members of Christine's family remain an essential part of her past and help shape who she is in a temporal sense. Christine enjoyed talking about her family, especially her grandchild, and we shared stories about grandchildren and our naughty family

pets; indeed, I found that this was how we came to know each other as I moved into a relationship with her.

Values

Christine graduated from a Bachelor of Nursing program in the late 1980s. Her first job was in a complex chronic medical unit. She experienced moral and ethical tensions while working with acute care in the hospital. She realized that, in her heart, she was more philosophically connected with primary prevention as opposed to the biomedical model of health, which focuses on treating disease. She stated it like this:

> *Working in the hospital did not fit my values because I was more on the preventative side. I really like the new transplants and the collaboration with doctors. But the medical side was sad, and people just died constantly. I saw a lot of patients become brittle diabetics and have their legs and arms chopped off and all that kind of stuff. Because I have my degree, I had many other work opportunities.*

Christine shared stories about when she had to challenge the institutional system when fighting for adequate patient care. She describes a situation that occurred early in her career when she was chastised by nursing management for giving what they defined as "extra care" to her patients. She describes this situation in the following way:

> *I've always believed in holistic health, not just physical. It's mental as well. So, I spent extra time with the clients with chronic health conditions listening to them when I did HS [bedtime] care. If I had a little more time, I would give a back massage. I actually got pulled into the nursing office and reamed out for providing extra care to clients. I responded that I'd get the union involved. I can give this kind of care if I feel it is warranted and needed to care for my patients.*

This experience must have been quite challenging for Christine, a new graduate; this story illustrates the power and control over her practice dictated by the nursing management even though Christine's care was exemplary. Nursing management chastised her for giving extra care to clients, which seems incongruous with the profession's caring nature. Because of Christine's

strength of character and commitment to a caring role, she was willing to act as a patient advocate when the nursing office did not see the need for special care for their patients. Here, the institutional narrative did not align with Christine's nursing values which dictated to her what exemplary patient care was. Christine links nursing care to the power structure in nursing in the following further comments:

> *I challenged them [the institution] on it....I was getting the dressings done, the IVs looked after, the critical stuff. I am good at time management, and now you're saying I cannot talk to a client that's crying? [After] this thing, I got home, went to my mom and cried, and she said, "You be you." Do you know what this is? And so, ever since then, I have always worked from a place where this is my practice. I do not care who's above me because of power structures and what they say I should be doing.*

Christine's mother was significant support for her personally and professionally because she was also a nurse and familiar with the nursing culture and nursing management's power over it, which is reflected in the comment she shared, "you be you."

Christine was promoted to Clinical Instructor on the medical unit she just described within that first year after graduating. Christine was one of only a few with a nursing degree on that unit at the time. After being in the instructor role, she realized she wanted to move into public health because acute care did not align with her values.

> *My values right from the get-go just did not fit with the hospital. My senior practicum was with the Director of Public Health; my summer jobs included public health and home care. I just knew my passion right from the get-go was public health.*

Within a year of graduation, Christine left her position in acute care in the chronic medical unit for a public health position, and she has remained in this area since that time. Christine talked about how she coped with early challenges to her idea of care and caring. She responded in this way:

> *I am from a long line of nurses, so I am feisty.*

What she meant by this comment was that she had many strong role models to help build her foundation in relational caring and advocacy, so she knew how to stand up for herself and her values regarding nursing practice.

Connection to Nursing

Christine has a strong connection to nursing from within her nuclear and extended family. Christine's mother and a Great Aunt were nurses, and Christine's daughter is a nurse. Christine's Great Aunt worked as a nurse during World War II and died after contracting tuberculosis. Since Christine moved to work in public health in the 1990s, she has remained in a few different roles.

> *My aunt was a nurse, my mother's sister. My Great Aunt Anna was a nurse in the war, and she actually died of TB.....So all the women in my family were well educated, teachers or nurses, pretty far back. My grandparents really believed that women should be educated at the university level. I initially just wanted to get my RN because my mom was out of the era when there were not many nurses with nursing degrees. If you get your nursing degree, I thought you just wanted to be in management. My mom said I was too smart and encouraged me to get my nursing degree. My mom told me, "you cannot just get an RN."*

Christine's family firmly believed in the value of education and that there was encouragement for women in her family to be educated. When we discussed feminism, I reviewed the definition of feminism which was shared in the Letter of Invitation, Appendix A: Feminism has been defined as a movement focused on changing how people see male and female rights and campaigning for equal rights. When I asked Christine if she identified as being a feminist, she shared an intersectional definition of feminism in the following statement:

> *I am not sure of the definition of a feminist, but I believe in equality for all, regardless of biological sex, race, religion.*

Many nurses were dissuaded from nursing as a career as feminists encouraged them instead to be doctors (Stillwell, 2019). I had the same thoughts about feminism, and it was not until beginning the literature review for this dissertation that I understood the reasons behind this.

Feminism was not a part of our belief system in nursing, particularly in the 1980s. Feminism was not a part of our story in nursing contextually, even though we believe in and advocate for equal rights. Although Christine felt she was unsure of my working definition of a feminist, once I reviewed it as shared in the Letter of Invitation, Appendix A, she did agree with the fundamental elements of feminism: equal rights regardless of biological sex, race or religion.

I Did Not Want My Daughter to be a Nurse

At one point in the first group meeting, Christine stated she did not want her daughter to become a nurse because she feared nursing burnout for her.

Christine's concern for her daughter's resilience was amplified during the pandemic when one nurse who worked with Christine's daughter committed suicide.

> *I just wanted to add one thing that's a Super Debbie Downer, but there have been suicides. My daughter did know that nurse that committed suicide. When nursing administration asks nurses to come to work even if they have symptoms [of COVID-19], they're so desperate for staff…. I wonder what the long-term effects there will be. I wonder what our mortality rates will be. I worry about us. I think there will be a health impact on all of us*.

This comment showed how Christine is concerned about how little thought there is from the nursing administration at a systemic level that their nurses are healthy. She says she worries about the pandemic's impact on nurses and the long-range implications of these experiences. In Christine's view, nursing management's main concern is that they have nurses working, regardless of whether they are sick. Her manager asked Christine to work from home one day because she was symptomatic. She described the tension this created for her here:

> *I just feel I am damned if I do and damned if I do not. There was a bit of pressure because even though I was sick, I was asked if I could work from home. I think that it is a bit dangerous because I feel depleted.*

Resilience

Christine noted that resilience was not discussed in nursing education when she was a nursing student in the 1980s. I know I had the same experience as a nursing student; there was no discussion about nursing resilience.

Christine defined resilience in the following way:

> *The ability to adapt and change to maintain yourself, your autonomy, and your self-care. It does not mean you have all good days, but I see resilience as a positive thing…. It's the way you think about something, navigate yourself into it, and choose to pull out the positives but still be self-protective regarding your boundaries. You must maintain that self-care…. I've learned to set more boundaries to last long term. I love nursing, and I do not have any plans of quitting tomorrow, but there are still days in the last two years when the idea of quitting creeps into my mind. I think this is because I have not navigated better boundaries for myself as a nurse. And you know what? When one nurse stands up, we all stand up.*

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Figure 2.

Christine's Collage

Christine, (2022). Thoughts on resilience during the COVID-19 Pandemic
Mixed Media, January 15, 2022.

Christine's Artist Statement:

It feels like a tree bent with one root holding it up, but the root is strong and the soil around it (your personal support system) keeps it in the ground. It sways and sways but stays grounded from client gratitude and small acts of kindness. Black cloud and support written in black represent the lack of systemic [health region] support or appreciation of all the stress components faced by nurses learning curves, modified surge service, unfamiliar sites, unfamiliar people and processes, changes in personal work schedules, and not working with work buddies to navigate all the changes.

Central to Christine's collage is the image of a bent tree, which she has labelled with the words "Bent Tree 1 root." Christine stated that, when she created this image in January 2022, she felt that, although she had a strong root, she was pushed to the point of touching the ground, bent but not broken. Later, in the first one-on-one conversation in May 2022, Christine shared the following when we re-visited the image that she had created and stated that at the time, she did not feel that she was coming out of the feelings of being overwhelmed:

> *I feel like we're coming out of it, but I also feel that this tree needs to come up slowly and mindfully. I need to think differently to maintain my resilience…. I think some people will not come back up. I know people that have quit.*

Christine's images show how she maintains her resilience through input from family and loved ones, mindfulness, and gratitude. Christine stated that her choice of the term history was significant because she hopes that as a profession, we learn from what we a profession have gone through during the pandemic and that historically this period in time teaches us and the institution ways to navigate better the burden it has placed on our resilience. Christine noted this in the following:

We cannot move forward unless we look at our history, we need to learn from history, or history repeats itself.

Christine stated that this is her sincerest hope, coming out of the pandemic, that we as a society and the institution learn from the impact the pandemic has had on nurses and doctors and that moving forward, the same mistakes will not be repeated.

Spirituality and Empathy in Nursing

Christine stated that she thinks that there is a deep and spiritual connection exhibited by nurses and shares the following thoughts about that and that she feels the pain of a patient in distress:

> *When we came out* [from nursing*], sometimes nurses were nuns, right? So we came out with a very spiritual perspective. And I'd say whether you have a religion or not; you're hard pressed to meet a nurse that is not deep and spiritual in whatever way and wanting to be there at whatever emotional level you're at…… When I see my patients in pain, I almost feel their pain. I swear to God. I find it so stressful because I have such empathy.*

In contrast, she noted that her daughter, who is a nurse, does not feel the same way as Christine when dealing with a patient in pain:

> *It's interesting, my reaction, whereas I am kind of proud of my daughter because she's kind of hardened, but in a good way. She says that she is not responsible for their complaining. There are pain meds. I am not responsible for their moaning. She has got a much better boundary than I would say I have.*

Christine stated that her connection to spirituality has helped her to cope with the stressors of working as a nurse during the pandemic, and she shares this in the following.

> *I've been spiritual over COVID, and I ask myself, why did I choose nursing?*

Do More with Less

Christine shared a deep concern about how nursing management has expected their unit to do more with less since returning from redeployment after the pandemic. Christine passionately described how much she would like to be valued for her work by her nursing management and that the level of complexity has increased significantly since the pandemic. She

described it in this way, and she again notes "they" when referring to the institution in this excerpt:

> *Specifically, I am mad at the system, especially how my unit is going. They are putting in management who do not know what they do not know and have zero compassion. There is zero navigation for the nursing staff and how they are feeling. Zero. I do not want money. I just want to be valued and recognized that we need a little breathing time and not to keep piling work on us. We are just expected to do more and more and more with less, less, less. They give us a little bit of a raise, but then they are not covering* [empty] *positions. So, the workload has been mounting significantly since COVID; we are getting even more severe mental health cases. Everything is more complex, with higher numbers. Most other referral agencies are maxed out, so we become a dumping ground.*

Even though Christine refers to her unit as a dumping ground, the nurses there have the ethical and legal responsibility to look after the patients in their caseload, adding to the taxing of their nursing resilience post-pandemic because referral centres are waitlisted. When a patient is waitlisted, the nurses must continue to follow up with their clients until a referral is completed. This adds to the workload and the significant ethical impact of doing more with less.

It Is About Feeling Valued

During the pandemic, Christine realized that she needed to look at ways to empower herself to be treated better by her managers so that she could cope with her feelings that the institution undervalued her. She described this in the following way:

> *If you do not really know what the people are going through, then you cannot empathize. I think what's lacking in nursing management is compassion. I've been reading up on research on team leading. What I am trying to do in my world is be a leader and try to take on management skills from my end and present them back to our managers. That empowers me to model how I would like to be treated …. I think people need to feel valued. It is not about money.*

Further, in the discussion about feeling valued, Christine stated the following about her feelings during the pandemic:

> *I love being a nurse; I have always loved being a nurse. This is the right field for me, but I have never felt so deflated, especially with that army mentality. So that does not support*

> *resiliency or lasting like it is sad when I love the job, but I want to retire like, it is just sad. And then you are losing staff because I've had so many younger nurses or colleagues come to me for support and experience. And I believe in mentoring and collaboration.*

Christine felt that the feelings of endangerment had subsided some in the present day, that she felt that her feelings were becoming more positive and that she was doing better since the first group meeting.

> *So* [that feeling] *was not consistent throughout COVID, but there are definitely times because when you walked in, and you might have to go to a vaccine clinic, you do not know where. And the perfectionistic person in me...There was not time to get to best practice, but not even safe practice.*

The impact of the pandemic on some of Christine's colleagues is palpable in the following comment she shared about the emotional toll that the pandemic has taken and her feelings of sadness about what some of her colleagues are going through:

> *I cannot tell you. I am almost going to cry. There are many nurses in heavy-duty counselling. They are on meds. They are getting trauma counselling. So, this has had a huge impact on our people, our nurses.*

Several months after our initial meeting as a group, Christine now feels that she is more emotionally optimistic about the future. She shares this hope for the future in the following comment and points to the importance she feels in acting as a mentor to encourage the resilience of the younger generation of nurses.

> *I feel a lot more hopeful. I would say now I feel a lot more hopeful going into the spring because I think that I need to think differently about my practice. As a professional nurse, I must role model for our younger nurses on how to navigate self-care and put ourselves first—teaching nurses to use the oxygen mask first.*

I Made a Difference

Christine feels that during COVID-19, her managers could have impacted her resilience by saying thank you, you are doing a great job. She found solace in knowing she was making a

difference to her clients and that she was proud to be a nurse during this time. She shares these thoughts eloquently in this comment:

> *Just saying, Oh my God, Christine. You did a great job. I got left with the whole caseload at work* [while the rest of the team was redeployed]. *I never got a single compliment. It is like could you go faster?* [from her management] *So, it was that mentality. Seriously, it is the mentality that they are not at all grateful for anything we have done. I have gone within myself. I have gratitude and ground myself with family…. I am proud to be a nurse at this time. And I get my strength from saying I am making a difference to COVID, making a difference to the clients, but I really hope someday we learn from this and that my daughter as a nurse never has to go through what I have gone through. It has been a very disrespectful time. I am proud of us. I am proud to be a nurse, and I am proud of us…. There has not been a single kudos.*

These were the highlights of Christine's story; I appreciated her candour, and I am optimistic that her voice and story will add to current knowledge in nursing about resilience. She shared stories not only in the context of the pandemic but also in the context of her history within her family and the nursing institution's culture. Christine frequently refers to a community of nurses as her people and the institution as "they." Her story, shared in the midst at this point, shows that she is feeling more hopeful, and she explained what things she thought were supportive in her journey toward resilience and the barriers to her ongoing resilience. Christine is deeply concerned about maintaining resilience for the generation of new nurses, including her daughter. Her story is both passionate and compelling and outlines her nursing resilience story, and she feels more hopeful for the future.

Emily’s Story

Emily has worked in nursing for 12 years but began her career in an acute care site. Emily graduated with her nursing degree in the 2000s. Emily recalled that there had been some mention of resilience during her nursing education.

Emily talked about her family in a way that showed warmth and emanated love as she shared stories about her nuclear and extended family. Emily's mother is a nurse, and she has had

a long career working in nursing management. Emily has a nursing degree and a second bachelor's degree; she is currently working toward a master's degree and has a love and appreciation for education.

Emily recently had a significant loss in her family following her grandmother's death due to COVID-19. Emily enjoys sharing stories, especially about her grandmother and the female members of her family, and it is apparent to me as a narrative inquirer that her family has helped to shape who she is today. Emily feels grateful that she was able to become a nurse; she shares why she is thankful in the following story:

> *I am so grateful to be a nurse. I am so grateful. One of the many reasons is that my Great aunt, who turns 91, really wanted to be a registered nurse, but my great grandmother told her that only lesbians became nurses.*

This story is an example of a story to live by that prevented her great aunt from becoming a nurse. Emily feels that she is fortunate that her choice of occupation was of her choosing and that she feels gratitude for the job. It must have been disappointing for Emily's great aunt to feel so passionately that she wanted to be a nurse, but within her family's culture, this was deemed an unacceptable choice. In the following generation, Emily's grandparents and because of their value for education, Emily's mother was allowed to become a nurse.

Emily stated that she identified as a feminist and believed that women should have equal rights to men. Emily was redeployed during the pandemic, first to the COVID-19 testing sites. After a few months there, she took an opportunity to work in a role within public health in a COVID-19 supportive role; she worked there until her redeployment ended in early spring, 2022.

I have known Emily for many years, and I have seen how openly caring and compassionately she enters into a relationship with the families and children in her care. Emily shared that her mother, a nursing manager, does not show emotion in her interactions with her

family. Emily thinks that her mother being trained at a time when nurses were not encouraged to show their feelings might have impacted how she does not show her emotional side even at home. She stated this in the following excerpt:

> *My mom is also a registered nurse, and she is much more old school. It is very uncommon that she would show her emotions. You know? You do not show your emotions; you stuff those emotions down. I think it is just that she has been conditioned and trained to shove them down.*

When asked about the impact of this strategy on her mother's nursing resilience, Emily noted that this has worked out for her but that she feels concerned for her mother's health from denying her feelings in situations. Emily does not share the same strategy as her mother, and she developed different coping strategies, which will be shared in the following sections.

I Felt Valued

During the early stages of the pandemic, Emily was redeployed to the COVID-19 testing sites, and she worked at many different places and was expected to sign up for shifts. She described the environment operating at the testing sites as difficult when there were situations where other nurses tried to show that they were more powerful than she was. She told those feelings here:

> *There were colleagues who are doing the same job as me that felt like they needed to tell everybody else how to do their jobs, even though they were not getting paid to do it. There were times when I thought, " I have been doing this as long as you; If it is just so that you can feel all-powerful, then it is not necessary."*

In the position that Emily held in a COVID-19 supportive role, there were many days that she worked overtime, sometimes as many as 15 hours a day, several days in a row. Her work site was understaffed, and the work she did could not be left to finish the next day. Emily appreciated the management style of the managers there because, as stated here, she felt valued for her

knowledge and skills. If she needed help, she asked her management team, and they supported her; she appreciated that.

What has been so refreshing is that we just do our job, and if we ask questions, we get support. It has been so different just to come to work and do my job and not be told every little thing you know.

In this role, Emily stated that she felt very well supported by her nursing management but that she found that the pandemic tested her resilience on many days. She summed up her experience in working with leadership in the supporting role she took after being at the COVID-19 testing centre in this way and realized from the knowledge that there are sound managers out there:

> *I have to say the management team, and least for my little area is amazing. I actually got a note from my one outbreak manager on the day after I had returned to my regular job. She said thank you for being such a good part of our team and being such a valuable part of the team. There are good managers out there.*

Emily defined resilience in the following way:

> *I think it is finding pieces of your environment and yourself that sustain you when things are perceived as difficult.*

Emily stated that something that helped her emotionally during the pandemic was when the public showed random acts of kindness toward the nursing staff. She said that these small things helped her during the dark times. She shares this here:

> *…. people, neighbours* [the testing centre] *would come and, you know, tape pictures to the windows for us and people would bring food and coffee. Those things they're small things, but they were really important…. absolutely that helped me keep going. It has been nice. It has been really, really nice to have that.*

Emily shared that she had supportive communication from her management in her virtual position during COVID-19 and that the team frequently received emails from their nursing

management thanking them for the work that they were doing during the pandemic. She shared this in the following comment:

> *Honestly, we do get kudos emails* [from our management] *not necessarily individually, but always that they recognized we were working really hard and trying really hard*.

Emily also shared her thoughts during the second group meeting about how disappointed she is that the nurses who were redeployed to do immunizations did not feel the same level of appreciation from their managers because vaccination made a difference to society as a whole:

> *It is really disappointing from your end because, honestly,* [nurses] *have had a huge impact. I cannot even say to you what a huge difference that made. Vaccinating, what a huge difference you made to our community.*

Emily shared how positive her experience was working with the management team during the pandemic and how rewarding that experience was:

> *I have to say that the management team, at least for my little area, was amazing. It's been nice, really nice to have that.*

As a narrative inquirer, I enjoyed Emily's positive stories about being supported and encouraged by her management team as her experience contrasted with my experience working during the pandemic. I was relieved to hear that she had a positive experience and found her stories heartwarming because I knew we were doing important work for the institution.

In the context of the second group discussion, Emily had returned to her permanent position, and she found that after the first day, feelings of being devalued had returned. She felt she would begin looking for a new nursing job after the first week; she felt unsupported and was returning to a toxic work environment. She shared her thoughts here:

> *I promised my husband that on Fridays, I will start looking for new jobs.*

Self-Awareness and Resiliency

Emily thought that what helped her to deal with the stress she felt while working during the pandemic were her conscious reflections about how she was handling difficult situations and choosing not to take her stress out on others. She described this shift into a self-awareness strategy to boost her resilience in the following way:

> *I know when we went into testing centres in March 2020 that what helped me was being self-aware that I was really anxious, I accepted that I do not want to be here, but I am choosing to conduct myself in a certain way. I am choosing not to take that out on other people—especially those in the same boat as you.*

Emily fostered her self-awareness when she was working from home during the pandemic in the following way:

> *I was just taking some time for self-reflection on how the day went and what went well, and what I could have done differently and then creating a "to do" list for the next day. I asked myself what made me feel upset. Just being honest with my feelings about what was going on.*

In this statement, Emily shared how she attempts to learn from situations daily to foster growth in herself. She goes on to say that she started doing this during the pandemic while working from home. She would like to continue using this strategy, but she thought that the most significant barrier to completing this was that she needed to make it a priority in her day.

Figure 3.

Emily's Collage.

Emily (2022). *Thoughts on resilience during the COVID-19 Pandemic*
Mixed Media, January 15, 2022.

Emily's Artist Statement:
Artist Statement: Five days of training in facility [support], an area I have always wanted to work in. A month after the five days of training, I was responsible for 24 facilities. One of these, in the end, had 49 COVID deaths in two months. This is not what I signed up for, but more importantly, this is not what healthcare workers or residents of these sites signed up for. The house in my artwork represents what a facility, someone's home, and workplace should look like. I felt a black cloud hanging over everything as I sat alone in my little room on a computer. The things that removed that cloud included caring for myself with physical activity and spending time with friends and family, which are represented by the sparkling heart. The heart also represents colleagues from all over the province and country. The energy emanating from this heart has helped to make me feel resilient.

The images Emily shared tell her story of resilience during the pandemic overshadowed by a black cloud and the isolation of working from home, a lonely figure working on her laptop. Also included are the textual representations of the 49 people who lost their lives to COVID-19 in the facilities Emily supported. This is the harsh reality of working during the pandemic, and people have died, and, somehow, nurses like Emily continued to do this important work. During the group discussion, Emily further described her thoughts and feelings about trauma working as a nurse during the pandemic and further interrogated her artistic collage creation. She used a compelling metaphor for how out of control she felt:

> *I am by myself in my little room, working on a keyboard, talking to people all day. You're just by yourself, right? You are physically by yourself, and you are not moving. I heard somebody talk about post-traumatic stress disorder. I remember thinking, I cannot move. Something really traumatic is happening, and I cannot move. I definitely felt that in this situation, with the 49 people passing away, I was just seeing this train wreck and trying to hold on. I could not find a picture of sand, but it was like I was trying to hold sand in my hands, and it was pouring out, and I could not keep it from spilling out. What made me resilient was just being active. Very active.*

Emily utilized physical activity to cope with the stress of her daily work, face the next day, and foster her resilience.

The hearts in Emily's collage expressed the support from her colleagues and that there was impending brightness in that relationship. She described those feelings in the following description about the meaning behind what she has expressed through her art:

I think it was support from colleagues and that there was a brightness in that.

Somebody Has to Do It!

Emily admitted that many times during the pandemic, after long and stressful days, she would cry in the shower at the end of the day to help her to cope. She felt that she was compelled to serve in this nursing role, especially during the pandemic, because many nurses around her were taking leaves of absence when the stressors were too significant for them to surmount:

> *It was incredibly freeing just to cry and be safe, and then I could face the next day, even though it felt like it was going to be the exact carbon copy of yesterday. It was just finding little successes in the day that really helped. Somebody has to get this job done. Somebody has to do it…. Nurses were dropping like flies; they were going on medical leaves. I thought, well, somebody has to do this.*

This philosophy and connection to her nursing role helped her during difficult days and enabled her to maintain her nursing resilience. She worried that if she did not help to support the facilities that she was working with, they would not get the support they needed because many nurses around her could not continue the work due to stress.

Emily's story shows a familial lineage to nursing and he stories of feeling valued and a compelling connection to a nursing role. Emily's story shows that when many other nurses were leaving during the pandemic, she stayed because she felt someone had to do it. What resonated in Emily's story to me as a narrative inquirer is the gratitude, she feels from being a nurse; despite all the challenges, she remains grateful to be a part of this caring community.

Ella's Story

Ella and I met several years ago when I had just moved to the city where she worked, and I started working at the same acute care site. Ella has a keen sense of humour, and I looked forward to working with her as I always knew we would have a laughter-filled shift even when things became tense. I will say this about nursing teams in my experience; if you have a good team who is happy, they work well together, and the patients are well looked after because the nurses are happy and enjoy being at work. Kallio (2022) noted that nurses' personal experiences affected their work motivation and engagement. From my experience, when Ella was working, work was a joyful place.

I took a job in public health in 2008, and our paths did not cross again until I saw Ella from a distance at one of the COVID-19 vaccination clinics. She was first redeployed to the

COVID-19 testing centres in March 2020 and then back and forth to the COVID-19 vaccination clinic starting in April 2021.

Ella graduated with a nursing degree in the early 1990s and has an arts degree. Ella stated that, in her experience, there was no discussion about resilience in nursing school. Ella defined resilience in the following way:

> *I think resilience is being able to cope with multiple stressors and still being able to maintain your ability to make good decisions and to keep your emotions in check.*

Ella worked in women's health until 12 years ago, when she obtained a position in public health. Ella and I had enjoyable conversations about our time spent on the same unit in acute care, and I feel a close alliance with her because of that connection. Ella enjoyed talking about her family, friends, and acquaintances from our shared history working in nursing.

Ella identified as a feminist and spoke warmly about how she grew up across the street from a friend of her mother, who was an active feminist. Ella's parents had strong feminist beliefs, significantly impacting how she viewed women with an equality lens.

Ella has an astute sense of humour, and we laughed as we talked about working in women's health together. Ella's tone changes, though, notably when she begins talking about her thoughts and feelings working in the pandemic. I noticed that the usual happy and open Ella I knew from the time I enjoyed working with her in acute care was gone. In its place, I saw a drained, drawn and tense demeanour as she recounted her experiences working in public health during the pandemic.

Feeling Valued

Ella shared with me a story that tested her resilience early in her career, but because she felt valued, the experience did not have long-term impact on her nursing resilience. The context of the story took place when Ella worked in acute care. A physician became angry during a

procedure and angrily pushed a patient into Ella, which caused her to propel herself into a piece of equipment, causing large bruises:

> *I was in a room with a woman, and there was an emergency. And this woman did not speak English, and her husband was there. There was a Dr…. he got mad and aggressively pushed the patient into me so hard that I flew into a piece of equipment and got a big bruise on my leg from it…. I remember thinking to myself, what just happened? And just the aggression and swearing were unbelievable….*

When the situation was over and the patient was safe, Ella shared the incident with her nursing management and the head of the medical team.

> *I think because I had been there for so long and I really knew the team of [doctors] well. They wanted to talk to me and asked exactly what had happened. I think he thought, no, we cannot have that.*

The physician who lost his temper during this encounter did not return to work there. I asked Ella what she recalls her feelings were at the time, and she shared that she felt valued by the nursing management and the medical team:

> *I felt that I was really valued as a nurse with experience, and this was one of the first times I stood up for myself.*

In this story, Ella described an experience where nursing management and the medical system supported her, and it was in stark contrast to my own experience I was reminded of as I came alongside her. We both noted that the first time we stood up against the medical establishment was monumental to our development as nurses.

I Am Insignificant and Disposable

Ella commented on the importance of teams in nursing and talked about how lost and dehumanized she felt when she was redeployed during the pandemic. She was often in different clinics every day, and frequently, she was outside the city in rural areas. She contrasted how she felt as a team member in acute care and how these differences affected her resilience. She shared these thoughts in the following comments:

> *When we worked in women's health, you felt like part of a team and part of a family. And so, for me to come into that* [clinic and testing centre] *environment and not have those people I can turn to and who are my allies. It just felt like I was just a cog in the wheel. Just sit down here. Does not matter. You do not sit there; go sit over there. You're still doing the same thing. You are all the same. It was very dehumanizing.*

Ella feels that the nursing management during the pandemic made her feel like she and nurses, in general, were not deemed as an essential part of the health care system. This lack of feeling valued impacted Ella's ability to feel a part of a team and her ability to bounce back from the pandemic experience. She described how she felt like she was disposable in the following excerpt:

> *Nobody cared. I felt disposable as a person. Again, nobody cared about us like we were just disposable, really. You cannot do it? Well, we will get another one. She will get in there. She will do it. I mean. I found that very degrading as well.*

Ella shared that something that harmed her nursing resilience was that her manager did not care enough to know anything about her during the pandemic. She described these feelings and the huge impact this had on her in the following:

> *The biggest thing I'm feeling is that she is focused so much on her upward path. It is like she does not even care about the people working in her programs. It is like she does not know anything about me. She has worked there now for two years plus, and she really does not know anything about me or anyone else on the team. I just feel very unsupported and insignificant, really.*

In addition to not feeling valued in general as nursing staff, Ella shared another deeply affecting thing: not being prioritized for vaccination until the public qualified based on age. She wondered why nurses working in these vaccination clinics in public and long-term care sites had to wait their turn with the general public. She described her feelings in the following way:

> *It made me so mad that, you know, we are expected to go and give these vaccines and not have it ourselves. We are still vulnerable. But, you know, give the vaccine to all these people. I'm like, wow, OK, so you really do not give a **** about me at all.*

The Hunger Games

Ella described how nurses were not given new schedules during the pandemic's first stages of redeployment. Instead, they were expected to sign up online for shifts in a "hunger games" type of atmosphere. She described feeling this also contributed to her thinking she was not a valued employee. She told this in the following way:

> *It was horrifying because when you are full-time and trying to get all these shifts in. They would not tell you the day, right? You would find out halfway through the day and have to scramble and try and get onto a computer and pick your shifts. It was so stressful. That whole thing was ridiculous.*

All staff were expected to fill their schedules this way, regardless of whether they had small children at home or were married to a shift worker. There was no concern for accommodating employees. Nurses in the testing centres had to stand on their feet for most of the day and also wear gowns, goggles and masks to perform the testing for COVID-19. Ella described working in the testing centres during the summer of 2020; she described a scene in a parking lot exposed to the weather elements standing on her feet all day, covered from head to toe with protective equipment. She told the following story of her frustration with how little they were valued as integral members of the team:

> *We were standing in these heavy gowns, masks and goggles in the hot summer weather. We had no shelter, standing out in parking lots. I remember one place had only two chairs, so you had to stand up even for your charting. When one of the directors came out one day, I remember thinking, I bet you have a chair to sit in. It was just unbelievable the working conditions we were expected to work in.*

Ella’s comment showed how frustrated she felt about being expected to stand all day in a parking lot exposed to the cold and hot weather and unable to sit to do her charting. This significantly impacted her nursing resilience.

Fear

Ella worked as a charge nurse in women's health and was a competent leader when I worked with her in acute care. She is a high-functioning, knowledgeable and experienced nurse. She managed many conflicting priorities when life and death hung in the balance. The lack of concern about safety and proper orientation to the vaccine clinic had an impact on her ability to cope with working during the pandemic, and she described the fear she felt here:

> *Orientation was half a day. I was supposed to have half a day with someone who was giving immunizations. They were supposed to watch me for half the day. I ended up watching an inexperienced nurse give two needles, and I gave two; that was my orientation. It was horrifying. I do not think I've ever given an IM in a deltoid muscle. I do not think I had ever done one. And so, I was scrambling… I was thinking, good Lord. I just was unsure. I just did not feel confident.*

Ella advocated for herself by asking one of the other public health nurses she knew from acute care to sit with her so that she would feel that she was practicing safely to manage the ethical tensions that she felt.

Ella was anxious about working in the vaccine clinic, but she felt more comfortable once she met experienced nurses she knew. Knowing that she had someone she knew whom she could go to made this challenge to her resilience less paralyzing. She described her feelings about the clinic and how dehumanized she felt working there: she commented on how the clinic was efficient but that they were not designed with the nurse in mind.

> *This vaccine clinic was not created with the nurse in mind. Honestly, it was more about how we could most efficiently do this. Who cares what it is like for the people doing the work? They just want to get as many needles in arms as they can, going as fast as possible. I think it was dehumanizing that the whole experience for the public coming into the clinic too. It was gross.*

Ella shared with me that, in addition to fear of making a mistake, she felt threatened by nurses assigned to watch how long it took her to give a vaccine. Ella said that she was

approached by one of the charge nurses, who told her she was working too slowly. (Field notes, June 29, 2022).

I did not feel I was practicing safely based on my orientation to the clinic.

I Am Not in a Good Place

Early in Ella's redeployment in the spring of 2020 and in response to her increased feelings that she was losing control, she approached her manager for support. She recounts how her manager told her to take her vacation time; she described that meeting here:

> *During the COVID 19 testing time, we were redeployed the first time. I was getting pulled everywhere and burning out, and I talked to my manager. I told her I could not do this; I cannot do this anymore. My manager said I should take some vacation time. She had no regard for human life. I think that I was shocked by the response when I said I needed help, I cannot do this, and she responded* [with the recommendation] *take my vacation time.*

The cumulative impact of the dehumanizing events for Ella throughout the pandemic and her return to her permanent job in 2022 shows the pandemic's ripple effect on resilience. She described this in the following comment:

> *I feel like that whole atmosphere chipped away at my resilience. Each day became harder and harder and harder. I think even now; I am not in a good place. For the first while, it was really difficult to do work. I was totally alone at home working on my computer. It was difficult to try and motivate myself to talk to people. I was shell-shocked. I would sit here; it took me several weeks before I could try and get back at it. I've spoken to our manager because I think it is true for a lot of us. I swear to God, I have never seen it like this. Like where nobody has any capacity, anything that is out of the ordinary is too much. It is too much stress. I cannot do this. Staff are on edge. There will be a mass sick leave, you know.*

Ella described having a conversation with her management about her concerns about herself and other staff member's resilience in their work in the spring of 2022 post-pandemic; she recounts the discussion here:

> *We tried to talk to the manager. I have said to her several times that people are not good, and she responded, well, tell them they can come and talk to me. I am a people person. I like talking to people. I am thinking to myself, nobody wants to talk to you about how*

> *they are doing. You are not a supportive person. You are not safe, you know, she does not have a soul….*

I Cannot Find the Gear Shift

Ella stated that she feels that she cannot seem to get back into the work routine since returning from her redeployment. The effects of working during the pandemic have continued to keep her from working at the level she was working at before; she remains struggling to find the right gear. She shared her thoughts about this in the following:

> *I think Emily when you said you felt like sitting alone and just feeling frozen like you cannot do anything. That's kind of how I feel now because you have come back to your so-called normal job, but it is nothing like what you left. You are sitting there doing zoom calls with your clients and phoning them. I am trying to get that energy back, the motivation to do my job, but it is so hard. It just feels like we are languishing. It just feels like I cannot find that gear shift again to get myself back into gear. I am asking myself how much longer I can do this, and then I can just stop. I am getting close to the magic years so I can retire instead of feeling like I can really turn this around.*

The context of this comment was taken in the January 2022 group discussion and collage creation. Here Ella used the metaphor of not being able to find the gear shift to get her back into her regular work. She remained feeling this way during our meeting in June 2022.

> *I think one of the most difficult things is when my values, what I believe is appropriate care for my clients, does not align with what my management sees as appropriate*.

Pathways to Resilience

Ella thinks that the things she has noted in her life that have helped her maintain her resilience are sharing stories she has experienced with other nurses and her spouse and having a sense of humour. She stated these things in the following:

> *A sense of humour has been helpful. I think having friends that are going through similar things that you are in it with. And your spouse. Definitely them.*

Figure 4.

Ella's Collage

Ella (2022). *Thoughts on resilience during the COVID-19 Pandemic*
Mixed Media, January 15, 2022.
Ella's Artist Statement:

I learned to stand up for myself. The little black cloud shows how I was feeling, which was not good. The sad little nurse in the corner was me. I learned to stand up for myself when I decided that I mattered more. The things that helped me were taking time for myself, enjoying the flowers and garden, nature and keeping physically active—spending time with loved ones—having the people around me who made me feel safe. This really made a difference.

I Have Nothing Left to Give

Ella began having nightmares shortly after she was redeployed during the pandemic. Today, in the context of post-pandemic and our first one-on-one conversation, she feels that she needs to

find a new psychologist to try and help her deal with the emotions she thinks are connected to nursing work and the spillover of negative feelings about the institution.

Ella sought counselling after a conversation with her manager, who told her to take a vacation, and she took a medical leave to try to sort out her feelings. Ella also shared how she seems post-pandemic to be in the same place emotionally again as the complexity of her work has increased, and she has found that the stress is building again.

> *I saw somebody for several months, and it was really helpful just to talk the experience through. Now that I'm here again, I need to start seeing someone again. I can feel it. I'm not in a good place. I have been thinking about it.*

Later, when I met with Ellen a second time, she had found a new psychologist and had met with her once. She stated that she thinks that she needs to go on medical leave again as she feels that she is so unsupported at work and that another leave is her only option to sort out her feelings:

> *I have nothing left to give….*; I *think we are in trouble because many of us are saying I'm getting the hell out as soon as possible.*

Ella hopes to retire as soon as possible; if she cannot, she will find a position outside her current one. She shared these feelings in the following comment during one of the group conversation:

> *No, I am ready to get out. If I were not retiring, I would definitely be finding a different job. Like you, Emily. It is not worth the life energy, right? If I was not ready to retire, I would be saying goodbye.*

Anne's Story

Anne and I met as colleagues during her early years in nursing, and we were re-acquainted during our redeployment to the vaccination program during COVID-19. I feel a strong kinship with Anne; she is fiercely independent and has a positive and uplifting personality. I always looked for her at the beginning of each shift so I could sit close to her and

feel supported. My time spent with her helped me cope with the stress of working during the pandemic.

Anne identified with feminism and stated that this is because she comes from a country where women do not have equal rights. She expressed her feelings about feminism in the following:

I am a feminist and fight for women's rights every single day.

Great Nurses Inspired Me

Anne lost her parents in tragic circumstances as a young adult, and she considers her grandmother a second mother and a significant influence on her. She stated that, when she was eight years old, she was hospitalized and that this experience influenced her decision to become a nurse. Even though she dreamed of becoming a nurse as an 8-year-old, she was not allowed to be one in her country of origin. She described her 8-year-old self as being inspired by great nurses during her hospital stay in the following story:

> *So, my* [dream*]to go into nursing came from when I was eight and in hospital. I do not know why I was in the hospital. I am not sure if I was asthmatic. I am unsure because none of my parents is alive to tell me. I was in the hospital for two months. They were using an injection, and I remember I would hang out with the nurses. They were so good to me, and I was inspired by great nurses…. I was a kid running around there, and they cared for my mom and me. I felt I would be a nurse, but education was not for everyone in our political system. Because of the cultural group, I was coming from. I could not attend nursing school, so I had to do accounting and commerce.*

Anne credited her uncle for her ability to become educated. This man saw the importance of education and had the means to provide a private education so she could attend better schools. The uncle's caring gesture and support for her education positively influenced her perspective about education and encouraged her to continue seeking her educational dreams.

Whoa, Me Too!

Anne was married and had a young family when she moved to Canada and began English classes. Anne was reminded of her dream to become a nurse by her classmates in her evening English classes. Anne did not know that nursing was open to her as a career in Canada, and she admitted that she forgot that as a young child, she had dreamed of being a nurse. Anne recounts this realization in the following:

> *I went and did English as a second language, and when I was doing it, someone was doing a presentation on what we wanted to do for work. I had no plan, and I was a new immigrant. I had kids; I had a baby. I was going to go to school in the evening when my husband would be home. Someone in my class said she wanted to be a nurse, and it was like, Whoa. Me too!*

Anne thought it was amazing that she could realize her childhood dream of becoming a nurse, which became her story to live by, changed by a shift in cultural rules with a move to Canada. The very distant memory that she had forgotten about was re-awakened.

> *I discovered during the presentation when I was doing English as a second language, I did not even remember the experience I had, and I did not remember* [that dream I had as an 8-year-old], *but it clicked the minute they talked about nursing, and there was like, oh, I always wanted to be a nurse as a kid.*

They Are All My Family

Anne recounted how difficult school was for her as English was not her first language, but she persevered and gained her qualifications as a registered nurse a few years later. She described attaining her childhood dream but recounted experiences in nursing that tested her resilience. Anne wondered why she had not become an accountant or a teacher during these challenging times. She described her first job working in the hospital as a struggle because the care she wanted to give did not fit with the reality of work in the hospital. On a personal level, Anne said she saw her grandmother in the patients she cared for, she identified with her patients personally, and this made it more difficult not to be able to give high-quality care.

When I saw them [my patients], *I saw my grandmother. I saw myself.*

Anne has identified with the empathetic role; Anne considers the children she cares for now in her nursing role as a part of her family, and her children and this philosophy guides and directs her care.

> *I see every one of those kids as my own. I put myself in their parent's shoes. When I am doing my job, I am doing it as if I am working with my own kids. My friends, they are my kids. They are all my family.*

This comment shows the profound responsibility that Anne feels connects her in her caring role.

Institutional Support and Resilience

Anne described her experiences working in the hospital as a new graduate who was utterly overwhelmed with the workload. She described thinking she would quit nursing altogether at times, as she felt there was little support in the workplace. She told this in the following:

> *I would have stayed in a hospital if the conditions were better. If I did not find something else, I was even considering quitting. During the first year...I did not even want to work basically because I was burned out because of a lack of support where I was working. That is why actually I was forced to get a job outside of the health region, where I worked in a private clinic. I would then pick up a shift at the hospital when I was at my best self. When I was feeling fine, I would go pick up a shift. Be nice to everyone. Do what I could do. Kill myself for a day.*

In this excerpt, Anne shared that although she did not find working at the hospital fulfilling. She felt a responsibility to go there when she was well rested and could be her best self, even though she admitted that it "killed her" physically and emotionally. She was drawn to care, caring for the patients she felt were family. Anne continued to discuss the impact of a lack of support from the institution in the following comment and how this also impacted the quality of patient care:

> *As a nurse, we are in a position where you can help other people…. you are able to give yourself to care, to be compassionate. It is easier to give that when you have support, when you are supported, meaning you are emotionally supported, you are supported*

> *physically…. If I am not able to feel good, there is no way I can give good care to my clients.*

Anne stated that she could not tolerate spending ten seconds with someone, doing the bare minimum nursing care and then running on to do the next thing. Anne described this in the following:

> *I hated coming and seeing someone laying on the bed who wanted all my attention or help, but I had no time. I'm running around. I know in some areas that's what nursing is, that's what the model is now, but I did not like it. I did not want to put 2 attends* [adult diapers] *on someone because I do not have time to treat people with dignity.*

Anne shared that she could give much more to her job now that she has a supportive manager post-pandemic. She described how happy she had been recently in this comment:

> *When you have trouble with management, it is hard. For example, now we have good managers who make you feel so good. I am going to work happy. I am able to answer questions. I can give myself and give more and more and more. But when there is no support, you feel alone and left out, and it is hard.*

Anne shared that the pandemic was a test of her nursing resilience. She said that it helped her be supported by other nurses she knew and contextually knowing that some nurses worldwide were in much more dire circumstances.

> *During the pandemic there was a group of nurses, and we were supporting each other. Even though it was also a hard situation. I remember when I saw a picture in the news, and we saw nurses around the world, some of them committing suicide. I remember I would appreciate that I was not in the same situation.*

Anne discussed that from her experience, although the pandemic was a test of her resilience, she knew it would eventually end, and focusing on its ending helped get her through. In the context of the pandemic, she thought nurses needed to be more resilient than ever. She described this here:

> *During the pandemic, it was a very good test to my resilience. The difference was that we knew the pandemic, at a certain point, was going to end; somehow, it was going to end.*

> *We are not going to be there forever…. I think we* [nurses] *suffered together…. So, we were able to support each other, but it was not easy. So, resilience at that time, we needed to be more resilient than ever.*

Anne thought that the people who supported her the most were the nurses she worked with. She felt many of them were like family to her. She described this in the following excerpt when she was talking about what has helped her to maintain her resilience:

> *I think nurses are like family to you; you support each other.*

Anne feels close familial links to other nurses and considers support an essential aspect of this familial link. Anne feels more than a connection to nursing culture; she transcends a nursing cultural link to a familial link.

You Cannot See and Touch Resilience

Anne discussed her thoughts about why she thought that resilience was not something which is openly discussed in nursing school. She shared a fascinating insight about resilience being a difficult concept to learn because you cannot see or touch it, you have to experience it in a way that life teaches you. She describes this in the following way:

> *Because some people do not know it, sometimes they do not talk about resiliency because they do not know it. It is not something that you touch. It is something you live and feel. It is not something you can prepare for.*

Anne shared her thoughts about why resilience for nurses is so important and why they should prioritize their resilience in the following comment:

> *…. because nurses are so important, they care for us, and we need them the most, so they should have that resilience, and they should be supported just like everyone else.*

Figure 5.

Anne's Collage

Anne (2022). *Thoughts on resilience during the COVID-19 Pandemic*
Mixed Media, January 15, 2022.

Anne's Artist Statement:
When COVID-19 savaged/ attacked the world! My world became attacked as well! I was redeployed, and my life became chaotic! When everything fell apart! I turned to my colleagues and my family! I appreciated the people who brought us little things; at least there was someone out there in our City, our Province, that still thought we are human beings! They brought us food from time to time! I was so grateful for their gestures.

Anne shared that during that pandemic when people from the public or her managers showed random acts of kindness her resilience was positively impacted. She shared that these gestures showed her that others were grateful and understood what the nurses were going through. She shared these thoughts here:

> *There was an LPN from the city; When her parents came to see her one time, they brought us food. I will never forget the effect of being on the front line; it is like being in Afghanistan or whatever. And there were a couple of community restaurants that gave coupons. I will never forget one manager. One time she brought us food, and I thought, Oh my goodness, that food was amazing, and then that is where you say, she is actually grateful, she understands.*

Anne went on to say that during the pandemic she felt feelings of isolation because she was not in her home unit with her work family. She stated how isolating these experiences were and how difficult it was to be redeployed:

> *It was hard and extremely hard when we were redeployed, without the support of our own family, our colleagues. I do not know if I could have been able to be here. At the same time, because we were not in our home units, you do not have anyone you know, like above you, to support you. So, we were on our own. Yes, you had managers and clinical leads, but these were people you did not know. People who do not know you. They did not know us,*

I Learned I Was Not Alone

Anne shared that another important thing that she learned by creating the artistic collage and contributing to the group discussion was that she learned that she was not alone. Anne realized that others were feeling similar feelings that she was feeling. She shared this in the following comment:

> *I learned that I was not alone, going through what we went through; for my future lesson, when I am going through so much when you focus on yourself, and you feel it is only you that is going through that it. It can break you; you can have your breakdown, but when you find that maybe someone else is going through this too among all these nurses.* [I realize] *maybe I am not the only one suffering, so that gives me some sort of energy to keep going.*

Anne stated that the collage creation gave her a new perspective and energized her and encouraged her to keep going. Contextually, the collage creation and group discussion occurred in January 2022.

Anne's sense of responsibility is aligned with her personal and professional identity. I have felt that as I entered into this relationship in the midst, I have come to know her in a way that I did not before. I learned that caring is a part of her nature and that she cares for and believes that colleagues are family. I am glad to have come to know her in a more complex and detailed way.

Chapter 6 Weaving the Resonant Threads

To this point in this narrative inquiry, I have shared co-composed accounts of nursing resilience obtained through my relationships in the midst of experience with the research participants. These shared experiences occurred within two group meetings, one-on-one conversations, and opportunities I had to clarify and understand their stories as needed. The participants were very generous with the time they gave me to complete this narrative inquiry. As a narrative inquirer, I have sought to share the co-composed experiences in an ethically responsible way. Participants reviewed all shared stories, and I obtained their permission to share direct quotes.

I noted that there was resonance in many of the stories about nursing resilience experiences. As I spent more time amid this experience, I began to think narratively about the lives of the research participants working in the healthcare institution and the context in which the stories took place. Additionally, I thought about how their experiences shaped their past and present and how this will affect their future. I have shared stories about working within the context of the pandemic and important stories about the participants because their experiences and stories have shaped their stories to live by.

Clandinin (2019) stated that people shape their lives by who they and others are and that they interpret their past based on these stories. Experience grows out of the experience and leads to new experiences; we live in familial intergenerational stories, personal stories and institutional stories. In narrative inquiry, Clandinin (2013) stated that a second level of analysis takes place after the individual narrative accounts as the researcher inquires across the narrative accounts to discern patterns and resonances where the stories overlap.

As resonant threads began to appear iteratively, they were woven together and shared in this chapter. These resonant threads are present in their stories about emotional labour, camaraderie, a black cloud, resilience as part of a developmental process, mentorship, and power over nursing by the institution, self-care, putting on the oxygen mask, thoughts about why nurses care and final thoughts about artistic expression. In Figure 6, I shared a woven textual collage that expressed the resonant threads evident.

Emotional Labour

Emotional labour was a theory introduced by Hochschild (1983; 2012) in which she described that helper professionals were not encouraged to show their emotions in capitalist society. Instead, emotions were treated as a commodity, and feelings were not shared between the helper and the person receiving help. The following will describe the stories shared about emotional labour and its link to nursing resilience during the conversations held in group and one-on-one meetings.

In the first conversation together, Emily described caring and its link to emotional labour and the toll it takes on nursing professionals. Emily defined emotional labour in the following way:

> *Yeah, my understanding of emotional labour is that you are supporting people through something emotionally charged. It takes emotional work to navigate feelings and emotions and get what you need to get done professionally. It is not like you are crunching numbers. You are dealing with human feelings, so I guess it is emotion with numbers if they had to do it with dollars.*

In the group discussion and collage creation, Emily described her feelings about COVID-19 and the emotional weight she carried when one of the facilities she was supporting had 49 deaths in 2 months. This was prominently expressed in her collage. She described these feelings in the following:

> *I was responsible for 24 facilities. One of those facilities had 49 people who died in two months. I was not the only one that was involved in this outbreak. Of course, there were other nurses involved, but this is one that was quite extreme and made me cry. Oh yeah, a lot.*

Ella talked about the impact of emotional labour on nurses and the corresponding interrelationship between it and nursing resilience. She described controlling her feelings under challenging times during her career and how she feels that they are re-surfacing now with the pandemic and impacting her emotional health. She thinks that the pandemic has been triggering emotionally for her. Ella told this in the following:

> *Definitely, the pandemic has re-introduced all those feelings and triggers. Like when you are dealing with women in the midst of death? And you are trying not to lose your **** with them. Just trying to shut that down, you know? The fear you are feeling when things are going badly, and you know you think, Ohh God, this patient is not going to make it. You are trying to stay in control of your feelings. I think that's what I have now, the nightmares I have when I am back on the unit. I am feeling those feelings again, that adrenaline and the fear that something bad is going to happen. I think it comes out in my dreams. It is triggering. It is triggering for me…. to relive those emotions. I think I feel like I have been stressed, stressed, stressed, stressed, stretched to the point that now things are starting to fray. Do you know what I mean? It is harder to keep myself controlled. I would be driving to work and cried so many times on my way, especially going to the* [COVID 19] *testing centre. That really was difficult because, again, I did not know any of the people working there.*

Christine discussed the impacts of empathy and emotional labour on nurses and her resilience in the following comments, where she thinks that, as nurses, we have empathy as a specific personality trait that compounds the emotional toll on nursing resilience. She suggested that, in response to this, she has found that she has needed to set up emotional boundaries to lessen empathy's impact on her resilience. She described these thoughts here:

> *We have a deep core of empathy which can cause burnout when you really can feel how people feel; that is hard. That is the emotional labour. You have to navigate better boundaries with that.*

Christine shared that she assimilated the idea that she must keep emotions in check from her mother, who was a nurse, and the nursing culture she adopted. Christine shared her thoughts about emotional labour in nursing in the following comment:

> *In terms of being a nurse at work, you are strong by not showing emotion. At home, you can be yourself and cry or have any feelings- I just meant that as a professional nurse, expectations from my training and my mom being a nurse, as well as other role model nurses in my life… No matter how mad you are, you hide your feelings and almost become like an actress, so you never show those feelings. I would say that is very cultural as well.*

Christine noted that she has read the research that shows that not showing your emotions is unhealthy. She shared this is the following comment:

> *I read an article from a physician saying the same and how unhealthy it was.*

Emily described a nursing mentor who showed her that showing her feelings in front of patients was acceptable. She has utilized this knowledge in her work with patients to show her human side, help her maintain her resilience, and lessen the impact of emotional labour. She discussed this in the following when she observed the first death of a patient as a nursing student:

> *I had one instructor. It was the first death I had ever dealt with as a student. It was an unexpected death. Some of the family members came in drunk because they were upset. A lot was going on. I was able to keep everybody calm…. As a Registered Nurse, my instructor was allowed to pronounce or call the death. So, she did. She got teary-eyed because it was really sad, the whole family was there, and it was unexpected for this family. It was really, really sad. I feel it is OK for me and my practice; it's OK for me to be human. I am not a robot. I will do my job, but I will also show my sadness and empathy for your situation. Absolutely. When I [show emotion], it lessens that emotional labour aspect. When I reflect on it, I feel better about it if I [showed emotion].*

Emily thought encouragement for showing emotion in nursing has evolved over the last few decades. In the event described above, she was encouraged by a nursing instructor to show her emotions in her nursing practice. Emily shows emotions in her nursing practice because of that early nursing student experience.

Conversely, Emily described that her mother is exactly the opposite in showing her emotions, and she thinks this is linked to her mother's education in nursing during a time when nurses were not encouraged to show their feelings. She shows this in the following comment:

> *My mom is also a registered nurse and is much more old school. She believes that you stuff those feelings down. I think she has been conditioned and trained just to shove them down.*

Anne discussed her thoughts about why she thinks resilience is not openly discussed in nursing school. She shared a fascinating insight about it in the following and made a connection between resilience and emotional labour in health care workers:

> *...Some medical people don't like to say how they feel and don't like to show their emotions because they think they will be looked at as weak.*

Anne suggested that healthcare workers do not want to show their emotions because they fear they will be seen as weak. Anne's suggestion partially connects to Hochschild (1983;2012) comments about the feeling of being a commodity in a capitalist society, and those caring professionals are encouraged not to show their emotions. Anne believes that resilience is the product of the experience that life teaches.

Black Cloud

The artistic collages that the research participants created during the first online group meeting were markedly similar in some respects, although none of the participants were in the same room nor discussed what they planned to express through their art.

I still recall my shock and amazement when three of the four participants in the online group meeting created collages with black clouds prominently displayed. I share this story because one of the committee members told me during my master's degree defence that similarities in the collages created were because the participants were impacted by what they saw others doing. I did not think this was the case, but I had no sound reason to deny it: until now.

Similarities created in the collages were shocking to some. Christine described when she saw that other collages looked like hers:

> *I just cued in on that I have a black cloud too!*

The black cloud that Emily depicted expressed the darkness that hovered over each day during the pandemic because no one knew when the end of the pandemic would come. She stated this in May 2022:

> *It was not knowing when on the darkest, hardest days. I guess it was hard to see where the end was.*

Emily said that she did not feel the black cloud every day, there were times when the waves of the pandemic ebbed and flowed. The image of the black cloud was prominent when she thought back to her resilience during that time.

Ella commented on how the black cloud in her collage expressed how she felt emotionally while working during the pandemic, her feelings of anger, fear, loneliness, lack of support, confusion, and sadness. She explained her thoughts related to the black cloud here and how shocked she was at the similarities among the collages:

> *It is funny. I have all the things that you did, Christine... Oh my god, I did the same thing where I had a black cloud. And I know in the black cloud I wrote like how I was feeling, which was like anger, fear, feeling alone, lack of support and confusion and a little sad-faced nurse.*

Ella also wondered about the underlying meaning of the black cloud encapsulated in the collage creations:

> *I want to know what* [the black cloud] *represents for us. Did we all feel that same foreboding?*

Ella shared how shocked she was about the similarities among the collages created by the research participants in the following. As a narrative inquirer and arts-based researcher, she wondered if I was surprised about that. She shared this question in the following comment:

> *It was shocking to me that so many of us had the same images or the same like that really shocked me. Was that shocking to you, or were you expecting that to happen?*

I recall thinking that it was not surprising that the research participants had similar feelings about working during the pandemic. What surprised me was that they expressed them so similarly using the image of a black cloud.

Institutional Power Structure in Nursing

The research participants all expressed that they felt a power structure in nursing that they felt frustrated and dominated by, and that this left them feeling voiceless impacting nursing resilience. Christine described how uncomfortable she feels with the power structure in health care and relates it to the fact that most of the nursing workforce are women.

> *…. but it is like there is a power structure because we are primarily women, even though we are really smart, we could have been doctors, a lot of us, we have taken a lot of extra courses. I have a high level of expertise. I had an experience recently where something went sideways with a child and a high-risk client. I could not even call my manager; I just navigated it myself because they did not know my job. There is nobody……I feel like I am talking to very uneducated people in terms of our management and even higher management. They do not understand the work, the client, or the specialty. Healthcare is not crunching numbers. I need a hands-on (manager) who needs some expertise, but they do not want high-level clinical expertise managers because they would give too much pushback.*

Christine felt that there is a significant move to non-medical managers that do not know the work involved and therefore do not empathize with her clients or the workload. Christine felt frustrated that her managers did not have a background in health, nor did they understand the ethical aspects of nursing care. She shared this feeling in the following comment and feared she

would make a mistake in the vaccine clinic, so she used her personal time to review emails and procedures to deliver safe care.

> *... but what I find is, unless you are in healthcare and you have been a worker bee as in a nurse or a doctor, and understand our ethical* [underpinnings], *how much we had to know to vaccinate safely. The managers with no background in health are not supportive. We are just a number in the assembly line to get the job done. And it is very difficult because I feel it is almost disrespectful…. So, I would say this is not the type of support-to-support resiliency.*

Christine became quite animated when talking about her time working during the pandemic. During the pandemic, Christine was faced with ethical dilemmas when she was told by nursing management to modify her visits with clients. She felt this created stress because she had to push her clients out and not address their concerns in the way she felt obligated to do.

> *It is kind of interesting, you know… I literally had a client with me.* [And I would] *have to leave the building to go and meet another client. We were just pushing people out, and ethically, giving such a modified service was super hard.*

As a researcher, I noted the tension in Christine's comments about feeling that the institution wanted to control her nursing practice that she felt did not match her nursing values. She said she felt this several times throughout her career and shared that this impacted her nursing resilience. Christine also shared how she felt like she was an insignificant member of the healthcare team and was not valued or respected by the institution.

Christine verbalized how she has felt that working during the pandemic has been a traumatic experience and that the disrespect she felt from nursing management added to this. She noted this in the following comment:

> *This has been, I do not know what the correct wording is, traumatic depending on what area you are in or what you already bring to the table in terms of resiliency. Especially when* [our premier] *came out trying to cut us and all that stuff. It was not about money. Oh my God, health is so important. We are keeping you alive, and especially the emergency nurses were actually having people on ventilators.*

Christine became a nurse in the 1980s and she said she has noted a shift in the power structure formerly dominated by the medical profession. She does not believe that doctors dominate the power structure in health like they did in the past. In the current she thinks there has been a shift in the power structure and that now the nursing management is responsible for domination and control over nursing. She finds this power structure very devaluing because often the nurse managers she works under are not nurses and do not have a medical background. She detailed this in the following comment:

> *The culture is changing; doctors today know they need nurses. When working side by side, the power structure is not so much with doctors. And when I phone doctors, they let me decide if the patient needs to be admitted. And they always agree with me. Our [nursing]managers, not so much. It is a struggle if they do not have any nursing background because we are not talking the same language; it is very devaluing.*

Ella wondered why nursing management did not attempt to keep nursing teams together as they were redeployed to testing centres and then to vaccination clinics. I noted a palpable tension as she shared this story. She described this in the following, and she openly wondered if this was a conscious effort by management to keep the teams apart as a part of an expression of power over the nursing staff. She thinks that working with a team she knew and felt a part of would have been helpful in terms of supporting her resilience.

> *Well, I mean, would you not think if you have full-time staff that you would make sure that they are going to go to the same place, have the same site, so that they can all come* [together]*, so we can have our team. We could have formed that team and had that sort of camaraderie. But no, they almost purposely wanted us scattered all over the place. It was such a stressful time; no matter what, you are in a pandemic and out there, dealing with people face to face. Would not you want to make it the least stressful? Would you think they would try and keep people together? No. It was like none of that was taken into consideration at all.*

Anne discussed the impact of power and control on nursing from the institution, resilience, and how this leadership style has affected the decision to leave, for some staff. She

described this in the following comment and uses the metaphor of colors on a painting palette to describe different management styles. She stated this here:

> *I can see power. Yes, you feel it, and you see it and touch it; all you see is that power and control. But when you go through different managers, I find it is also a part of an individual manager. I think they come in different colours, and I do not know if they are actually trained. I wish they could be trained to see that they are the key to the services we provide. If you are supported, the managers should be there to support us. If you are supported if you have managed to where you give your best…. The [manager] we had during the pandemic was a micromanager, a control freak, she was about herself and no one else, and that was not easy for everyone working there…. That impacts resilience. You can see how many people have left, how many, even though we all support each other below her. But it is not enough when you are in a leadership position. If you have too much power, you can affect your team a lot.*

Emily shared the following comment about power and control over nurses in the context of public health. She wondered why these managers seem so angry when it is a place in healthcare with a primary prevention focus that should be positive and fulfilling. She noted this in the following excerpt:

> *I always think we should be so happy to work in public health. I just always wonder, why are* [the managers] *so angry? Like why?*

In this conversation, Emily wondered why the public health managers express their power and dominance over their staff in anger. As a narrative inquirer, I wanted to understand how this impacted her story to live by. I asked Emily how this management style affected her nursing resilience. She responded to that here:

> *I think it has taught me to rise above. It has built resilience. You can be grumpy, but I will choose to have fun with the day because I work in public health. How lucky and wonderful is that?*

Despite working in a work environment characterized by managers who lead from a place of anger, Emily has chosen not to let this environment impact her resilience or her love for the professional role. This is a significant choice she has made to support her resilience.

Emily wondered whether the power and control of women over other women in the institution have resulted in a system where those in authority are unaware of how they're using their power. She wondered why, from a feminist perspective, they don't understand that women should support other women. She shared these thoughts here:

> *I wonder if it is that there is some unawareness of what we have all internalized around control and power and women who are controlling other women. I wonder about that. Is it just internalized so that they are not even aware of what they are doing or why they are doing what they are doing? There is a reason behind the behaviour, of course, but maybe there is a lack of awareness, I do not know. I mean, we are the system…. I also think because it is still not always common for women to have power, maybe people, women who have power, they want to hold on to it, like my precious. It is hard to open the doors and look at how to build other women up and have them join you at the table.*

Emily detailed the differences between how her husband is valued and encouraged at his workplace to take time off to look after their children if they are ill. She highlights how nursing is a female-dominated profession, yet she has not experienced support for her needing to stay home to care for her sick children. She iterated this in this way, and this comment further elucidates the power and dominance of the institution over nursing:

> *My husband has an amazing employer. They have been such a gift. His employer has been so understanding of him, like just being a young parent. They have told him it's OK if you need to take sick time. It is all good. I think like I am in a female-dominated profession. You would think that there would be some more support for women.*

Christine felt she had no identity because her nursing management treated her like she was a faceless employee. She has noted that this has contributed to tests of her nursing resilience during the pandemic.

Anne and I experienced a disturbing display of dominance and control at the immunization clinic we worked at one evening shift. This story took place in May 2021 and the long line ups and demand for vaccinations had diminished. To this point many of us had spent months working overtime to meet the demand. It was relieving to see that we had worked

through the long lines to this point. One evening all the nurses at the clinic were done cleaning their stations and restocking their supplies, and there were a few minutes left in the shift. Nursing staff had to store all their belongings in a room several minutes from the main immunization clinic. Because all the clients had been vaccinated, nursing staff began walking to the lockers to retrieve their belongings and walk to their cars, a further 10 minutes away. This evening, the door to the exit was blocked by nurse educators tasked with keeping nursing staff from going to their lockers, even though their jobs were complete. Nurses were barred from leaving. This example made explicit the domination over nurses in this expression by management in a deliberate attempt to keep nurses locked in a room until the last moment.

Feeling Powerless

While the research participants shared their stories of working during the pandemic, a resonant thread which wove in and amongst the conversations were feelings of powerlessness. This thought wove through their stories of fear about the pandemic and around the organization and management of the COVID-19 sites.

The research participants shared feelings of powerlessness in the participant's individual stories. Still, it is also important to share this thread within the context of the institution's power, dominance and control. The research participants expressed frustration during our conversations outlining how experienced public health nurses were not asked how best to manage this public health crisis. During all shifts, there was an assigned charge nurse; this nurse manages problems on shift, makes last-minute decisions about staffing, helps nurses manage questions related to nursing practice, and deals with families. The charge nurse is typically expected to have many years of experience and is a well-respected resource person who manages crisis situations well. During the COVID-19 pandemic, the charge nurses at the different sites, particularly during

testing and immunization, were typically new graduates, elevated to charge nurse status with little or no public health or nursing experience.

In the following comment, Ella shared her feelings about the choice made to have new nursing graduates function as charge nurses. Ella felt that this expressed to her that nursing management did not value her level of expertise in healthcare. Ella was annoyed about the disorganization and chaos that ensued because the charge nurses had little to no public health experience. She felt that this was a dehumanizing experience.

> *Who was in charge? I just felt like who is in charge here, and all these young charge nurses, these young girls, they were in charge. You are nothing. This was demoralizing. You want me to come to them if I have an issue, I am like 50 something? I have got 30 years of nursing experience, and you want me to go to them.*

Anne shared that the experience working in the pandemic showed her things about the system that she had not examined before. It led her to wonder why it seemed that the institution did not want nurses with expertise in public health in charge nurse positions. She noted her learning moment about the institution here:

> *It was a learning moment about the system. People who were public nurses with over 10 and 20 years were managed by a nurse who had just graduated.*

Christine commented in depth on using inexperienced nurses as charge nurses in the clinics and how this contributed to the chaos and waste. This also impacted how she felt powerless and disrespected in the context of the pandemic.

> *The discrepancy and how they use resources because it was not organized, and it was brand new grad grads that were in charge of the clinic…. charge nurses with no experience. I am just saying it is a mess if they do not have it organized from the top. It was just a mess…. I was embarrassed and did not want to be known as a* [health region] *nurse. I was so ashamed of how the health region ran it, to be honest, when I was there as a client.*

Christine also thinks that the choice to hire charge nurses with no experience was a decisive one made by the institution because these inexperienced nurses would not ask questions of the institution.

> *It was a strategic choice* [by management] …. *When you have got brand new grads running it, and they are sitting around chatting... but I blame management; higher up, for whatever their reasons, it was not the best outcome for nurses. And it was not the best outcome for clients. And it was not cost-effective either.*

Christine noted that being treated this way by the institution harmed her resiliency. This is elucidated in the following excerpt:

> *So, when you look at all the* [health region] *values, it was not collaborative. There was not transparency. There was not respect for experience…. there was an effect on us, and I think there will be research later on about what we as healthcare providers have gone through. It has been traumatic.*

Emily noted that the use of inexperienced nurses functioning as charge nurses was a management structure that she heard was chosen in other provinces as well within her network of public health nurses. She noted this here:

> *I know public health nurses from XXX province have the exact same stories where public health nurses, with many years of experience, were redeployed to vaccinate and that it was young, grad nurses in charge of the clinics. Exact same story; so traumatizing for them as well.*

Christine commented that as a nurse, the cumulative effect of the disrespect had led her to feel that the institution looked at her as only a worker. She stated that she said she was simply a member of an army, being told what to do by her superiors like she imagines happens in an army experience. She felt belittled by being treated this way by the institution. She described this poignantly here:

> *I have never felt this way before; it is kind of like the attitude of tough **** We are the army ants by those kinds of things, you know, that is all you are.*

Camaraderie

As we discussed and shared nursing resilience stories, the research participants shared how vital relationships with other nurses are. I know that from my perspective, based on my experience working in both acute care and public health, what made the work enjoyable was a great team. The team I worked with helped me through the happy or sad times; they supported me emotionally.

I think back to the story I shared about returning to public health in August 2020 and how stark it seemed with so few staff there, many still redeployed. It was evident that there was a complete loss of the team aspect of my work that made it enjoyable. Once public health nurses started returning from the testing centres in October 2020, there was a renewed workplace atmosphere. Nurses shared experiences about working at the testing centres and how they coped with shifting schedules and working at different sites. There was a sense of relief when nurses could share their experiences. There was a palpable sense that, now that the nurses were back at their home sites, they could return to a more normal existence. As I explored this research almost two years later with the research participants, this camaraderie was noted as vital in the research participant's stories of resilience. The sense of connection in the shared stories was an important one, and it was evident to me that this thread needed to be explored more as I spent time reflecting on the shared stories.

Ella shared the importance of teams during the pandemic, and she stated that she thinks that it was her nursing colleagues who helped her survive. Ella thought this was particularly important because there was so much unknown about COVID-19 at the start of the pandemic. She shared that she witnessed anxiety manifested differently in the other nursing staff at the different sites where she worked. Sometimes she stated that she observed discourteous behaviour

in the nursing staff she worked alongside. She explained the positive impact that working alongside nurses who were familiar to her had on her nursing resilience during the pandemic in the following way:

> *When you talk about having your team around you or your friends around you, that was so important because, at the beginning of COVID 19 testing sites, you just got pulled to all these different places. I did not know anybody a lot of the time, and people could be quite rude. I think just because everybody was so burnt-out and anxious, I do not know if I would have survived without my colleagues.*

The importance that teams made to her ability to cope was apparent to Ella when she had the experience of not having her team with her during the pandemic and her redeployment.

Christine described the impact that familiar teams and camaraderie had on her resilience. She shared this vivid description in the following story:

> *I felt sorry for people that were doing it cold, right? I had a security blanket, so that is part of what I would say about my resiliency. There are different ways to get support, but having a friendly face comforted me*.

Emily shared a story of how grateful she was to have a colleague she knew would support her when she had to go into the long-term care sites with outbreaks of COVID-19. No vaccine was available yet, and public health nurses doing the testing were working under perilous circumstances. Many described the experience as being sent into the eye of the storm when COVID-19 was ravaging long-term care sites. She shared that having someone she knew made the experience less scary. She shared her feelings in the following story here:

> *I went to a bunch of facilities with a colleague to test people in long-term care facilities. It was just nice to like to have someone I knew with me. I just did not feel so scared because I had a friend.*

Anne thought that what helped keep her resilient during the pandemic was the support she felt she got from colleagues she knew. She described this in the following comment that she shared during one of the group discussions:

> *We supported each other. Nurses supported each other. I think that is what made us resilient at that time.*

Emily shared an exciting story about her experience with a supportive group of nurses she had met through their work held in online meetings. She shared that experience and that she felt that this group had built a network of support from across Canada in the following comment in a virtual work context:

> *Just having the support of coworkers has been huge, and we have never met in person. There were people in XXX. There were people in XXX. There were people in XXX, and we just talked to each other and helped each other out. It is such a weird thing because I have never met them in person before, and yet I found they are these amazing people…. and just hearing those colleagues' stories, we built this network of support from all over the country.*

Ella shared that what supported her was when she worked with nurses that she knew. She said that there was a sense that they were all going through the same thing as a collective group. She felt comforted by this, and it supported her resiliency. She described it this way:

> *You had to have your people around you, I think.*

In this comment, Ella shared that the colleagues she worked with were "her people" and integral to her feeling supported. Emily recounted that being part of a collective experience and, like Ella, the importance of having "her people" helped her realize that she was not alone. Other nurses felt the same trauma as her in her work during the darkest days of the pandemic. She remarked about that here:

> *Having people in Ontario and people on the East Coast, and people in Vancouver, having so many different colleagues, hearing their experiences and realizing I am no different. It was good to feel not special. I was not the only one being traumatized; all of us were traumatized in some way.*

It is clear that a sense of belonging and feeling a part of a team is an important part of resilience. This idea was one that all the research participants felt was missing in their experiences working during the pandemic.

Mentorship and Resilience

The subject of mentorship was inherent in all the research participant's stories. All felt the need for more mentorship because of its positive influence on nursing resilience but most had little formal experience with it in their nursing careers.

Emily noted that the idea of mentorship is essential in nursing, but it seems that it is not promoted in the institution. She thinks this is because nurses are expected to be self-sufficient and function independently, even if they have just graduated. Emily says that mentorship in nursing is considered a "dirty word." She shares this thought in the following excerpt:

> *Why is that such a dirty word? I find it very funny that people expect you to automatically know how to do things or that you need to be ultra-confident but not too ultra-confident because then you are scary and dangerous. It seems like in nursing, you need to be confident, so people know you know what you are doing.*

Emily thought that the idea of a formal mentorship program for nursing graduates would be helpful because other nurses' experiences and learnings would be helpful to her nursing practice. Informally, she thought that she has learned a significant amount from more experienced nurses that she has met on the job. She shared these thoughts about nursing mentorship from more experienced nurses in the following comment:

> *Just sharing your experience, what had happened in your career, and what you had learned. I appreciate those stories because it helps. I internalize those. I learn from them, so I appreciate them so much.*

Emily also shared how much she has enjoyed teaching younger staff now that she is experienced and can share what she has learned while working. This idea of mentorship would be an important supportive element to nursing education:

> *I love teaching other people. I really love it.*

Anne feels that a mentorship program would have been helpful as a new graduate to help her believe that she had someone to support her when needed. She describes a lonely type of

existence as a new graduate and one that led her to leave the institution and take a position in a private clinic.

> *I think mentorship would have been the best thing I would have gotten. Maybe that's what made me say this is not me. This is not for me. This is not what I am looking for and made me look outside* [the health region],

Anne also felt that it was challenging for her to fit into the hospital unit because she thought nursing school did not prepare her for the reality of life as a nurse. Anne also explained that learning resilience through formal mentorship would help nurses be more resilient. She shared this here:

> S*ome people are not supported to be resilient. Or they have never been in a situation that would make them resilient…. School does not prepare for the real life of a nurse. There are no areas where you have mentoring; you are just students. You do not deal with any extremes; you do not have full responsibility. If nursing school better prepared you at the beginning and you had mentorship, I think you might know more lessons and be more resilient.*

Christine displayed a love and appreciation for the nursing mentorship and support she received from her mother or nurses on the units who knew her mom and remembered her. Christine's mom was a well-respected nurse and someone she could turn to when she found challenges navigating her role as a nurse within the institution.

> *I was mentored and supported well because my mom was very well respected. On my surgical rotation, I got one of the best surgical nurses who took me on. When I was at the XXX doing labour and delivery postpartum, they still remembered my mom. And because she graduated there, they could just tell by my last name. I was in, like, they just treated me like gold, and I would have been hired….*

Here, Christine described that because her mother was a well-respected nurse, she received competent and interested mentors that helped make the transition into nursing more accessible. She had her mother as backup on the days that she needed her. The mentorship was an essential foundation for the development of her nursing resilience.

Resilience is Part of a Developmental Process

Resilience as a part of a developmental process based on previous experience was a resonant thread repeated by many research participants. Emily explained the development of her resilience as a part of a developmental process in much the same way that Dewey (1938) saw the growth of experience building upon previous experience. In Emily's view, the pandemic tested her resilience. Still, she felt she could better manage the stressors because of what she had previously learned in her career when dealing with stressful situations. She described this development of resilience in this way:

> *I think I have had similar tests in my career, and I think I have coped with this better than I coped with those past ones. So, I think those past ones have built up my resilience. It is just knowing you have survived, going through something, and came out the other side. Even though it is dark right now, it is about knowing and trusting in myself that I will find my way out.*

The staircase depicted in Christine's collage showed how she has felt with the ongoing COVID-19 waves with varying restrictions. She described the use of the imagery of the staircase to express her feelings. She said that with each step, her resiliency has had to keep developing even though she considers herself a resilient person.

> *I actually started with this staircase thinking about resiliency and the newness of it. I feel I'm a fairly resilient person. But during COVID and even now, I feel like I am on this staircase, and it's just one step at a time. We are still dealing with it, so my resiliency has to keep developing.*

Christine shared that the institution has not recognized that resilience must be supported and fostered from within the system. She expressed this thought here and elaborated on using the black cloud here.

> *The support, unfortunately, overall feels a little bit black to encourage resiliency, so I think that you build on strengths, and I think that as nurses, we have a lot of resiliency, but I think that there has not been that recognition that you have to keep supporting and encouraging it.*

Christine thinks that resilience is essential not only in nursing. She thinks that it is also integral to individuals personally and financially and that it is linked to overall happiness and is developed over time:

> *Resiliency, I think, is critical, especially if you want to last in a field or as a parent you have got to be resilient… I think that resiliency plays a role in our lives personally, professionally, financially, and it is something that will help have a happier life if you have the ability to keep developing your resiliency.*

Anne's positive and caring attitude comes out in the following quote when she talks about how resilience can be fostered through support, mentorship, love and caring. Anne believed that resilience is learned as a part of a developmental process based on experience and is contextually derived based on life experiences. She described this in the following:

> *Sometimes going through things helps you grow and help make you stronger. Some people learn resilience at a younger age, depending on where they come from…. I think it is a learned experience. I think that's where you learn it. Through mentorship, through support and when you have tons of love and true experience.*

Why Do Nurses Do It?

I recently had a conversation with a professor on my Ph.D. supervisory committee, and she said that nursing sounds troubled; why do nurses do it? (L. English, personal communication, February 2021). That comment caused me to reflect on why I do this job; with all its challenges and perils, what is it about this job that compels me to continue doing it, and this became a large part of my research puzzle for this Ph.D.

This subject also emerged several times in this research during the conversations and stories shared as I came alongside the research participants. I wondered what they felt nurses get back from the caring relationships that they enter into.

Emily shared that, despite all the challenges and tests to one's resilience, she remains grateful for her role as a nurse. Emily is focused on the good things she gets from the caring relationship, not the adverse effects of managers on her resilience. She described this here:

> *Yes, you have to lob on to that positive thing. I am choosing not to let you ruin my day. You over there because there is too much good and fun over here* [caring relationship].

When talking about the positive benefits a nurse receives from the caring relationship, Ella shared that currently, in the context of her work life, she no longer feels that she gets anything back from the caring relationship. She talked about this in the following comment:

> *Like what I give out? I do not feel like I get anything back anymore. Like, not enough to keep wanting to give.*

Ella talked about the synergistic relationship between nurse and patient and how this is part of what keeps nurses doing the work. Ella thinks that nurses get something back from the caring relationship they enter into with their patients and that she has experienced that herself. The pandemic has impacted what she gets back; she says that the balance has shifted and that what she gets back is not worth staying with the institution. She explained this in the following during a conversation we had in June 2022:

> *You know, the love you get back from people when you are caring for them was huge, but I feel like now that balance has shifted. Right now, it is not enough.*

Christine shared that she also feels she gets something from the caring relationship she enters into with her patients. She stated this when asked what she thinks about the existence of a synergistic relationship:

> *100%, there is a relationship there. I'm making a difference. I love that we are a collaborative team navigating your health. I love finding out how they can use me in their journey and navigate their goals.*

Anne has felt that she has gotten something back from the caring relationships she has entered into; however, that has changed as she has aged. She has realized that she gets little back as she has gotten older. Anne described this here:

Yes, I used to get a lot back from the caring, but now I do not feel I get as much back.

Self-Care and Resilience

The research participants all shared the importance of self-care in their pathway toward nursing resilience. Christine stated that, in her experience, resilience is viewed differently by different people depending on their perspective on the situation. She said that one important thing she learned from navigating her work as a nurse during the pandemic was the importance of saying when work demands were too much. She also noted the importance of self-care and setting professional boundaries in maintaining her resilience during the pandemic and commented on the community in nursing in one nurse standing up.

Christine said she does not believe that her nursing management encouraged her to look after her self-care needs. She felt that there was resistance to that idea. She expresses this in the following:

There is resistance to that… or at least I feel there is resistance to your own self-care.

Christine stated that she decided to make self-care a priority for herself regardless of what the reaction was from her nursing management.

In Ella's artist statement, she talked about self-care as essential to remaining resilient even though the pandemic was a test of her resilience. Ella found that in addition to realizing that she needed to care for herself, including standing up for herself when she knew she was not coping, she began spending time enjoying nature and staying physically active.

In Emily's artist statement, she shared the importance that physical activity played in maintaining a resilience level during the pandemic. She stated that in addition to physical activity, spending time with friends and family helped remove the black cloud she depicted as hovering over her during this time.

Anne stated that she has realized as she has aged that making self-care a priority has helped her in her pathway to resilience. She said that she sets aside at least an hour a day to do some physical activity like yoga, hiking or walking. She stated that she has learned that this takes priority at this stage in her life, and that she has given a lot in her caring relationships both at home and work.

Put On the Oxygen Mask

Christine described how nurses tend to look after everyone else before they look after themselves. She used the metaphor of putting an oxygen mask on yourself first. She said nurses do the opposite of putting an oxygen mask on themselves first. She said it this way, and she refers to nursing management as "they"

> *So, I am pushing back in terms of my need for self-care. If you are on an airplane and have a baby, you put the oxygen mask on yourself first to look after the baby. What did we do during COVID? What did I do first? Looked after everybody else. I did not put an oxygen mask on myself. I do not know if that's a good analogy. I feel like I am gasping for air. They* [nursing management] *think we can do the exact same program with one nurse as opposed to four FTE* [full-time equivalent*], so I think again, if you do not set your own boundaries, nobody else will. That is what I have learned.*

Christine recounted a story about how she promotes the importance of self-care with her daughter much differently than she learned from her mother. She thinks that nurses in her age group have had difficulties prioritizing self-care. She described this difference in the following:

> *So, what I am finding enjoyable is that I am so happy for my daughter, and she loves being a nurse. I navigated encouraging her self-care differently than my mom navigated*

> *with me. If she is sick, I tell her you are off work, girlfriend. You need to look after yourself first.*

Christine noted that when she was sick, her mother would still encourage her to work because work was a priority. She has since realized that the system would quickly replace her with someone else.

> *My mother would be nice, she would not want me going there if I was really sick, but Oh my God, if you are in charge, you better get there. Right? Because who else would do it? So, the instant I leave tomorrow, even though I feel like I have given a lot and I an high calibre, I know they will replace me with a 22-year-old.*

Thoughts on Artistic Expression

During Ella's second one-on-one conversation, she asked if I knew that the process of creating the collage and talking in the group meeting and the one-on-one meetings would be so helpful. Before this meeting, Ella had seen Christine, and she spoke with her about coming to meet me. Ella said that Christine had shared with her that she was grateful for the experience of meeting and the art creation; she wanted to let me know that the experience has helped her. She said that she found this entire experience and that talking with other nurses about how they felt has helped her realize that she was not the only nurse struggling.

Ella shared that she enjoyed the collage creation and that not only did she find it cathartic but also that it was emotionally relieving to her. She said that seeing other nurses share similar images in their collages about nursing resilience helped her feel that she was not the only one feeling that way. Ella described this in the following way:

> *I really enjoyed that because I do not think I had ever really sat down and thought about what it was that helped me get through that. Doing that collage was cathartic, putting it on paper, speaking it, and writing it down. That was good. It was shocking that so many of us had the same images. That shocked me. Really cool because I felt like I am not crazy. Everybody is feeling this way. That made me feel like, OK, I'm not crazy. We are just all like burnt out.*

Anne enjoyed creating the collage because of the process of expressing her feelings about resilience, the carryover impact for the viewer being able to see what she had described, and that the art will live on in history to inform the future about what nurses went through at this place in time. She explained this here:

> *Looking at what was in my mind was a good expression of what happened to me or what I saw around me. Without thinking about it, the impact. I was able to get out of me without actually saying anything. Also, someone can see it and have their interpretation and see what I went through and see how I was feeling and then they can maybe draw from that when we are talking about the pandemic, and they will see, Ohh, this is how nurses felt like back in that time, inside them. This is what they felt. This is how they felt. I think the art was good. It also made me say things out of my brain using art.*

Anne shared that another important thing that she learned by creating the art and contributing to the group discussion was that she learned that she was not alone. Anne realized that others were feeling similar feelings that she was feeling. She shared this in the following comment:

> *I learned that I was not alone, going through what we went through; for my future lesson, when I am going through so much, when you focus on yourself, and you feel it's only you that's going through that, it can break you, you can have your breakdown, but when you find that maybe someone else is going through this too among all these nurses. [I realize] maybe I'm not the only one suffering, giving me some energy to keep going.*

Anne stated that the collage creation gave her a new perspective, energized her, and encouraged her to keep going. Contextually, the collage creation and group discussion occurred in January 2022.

Christine noted that she was surprised that the individual collages created had similar themes about nursing resilience during the pandemic. She described this here:

> *I think that is what is the most shocking to me, how similar the themes were.*

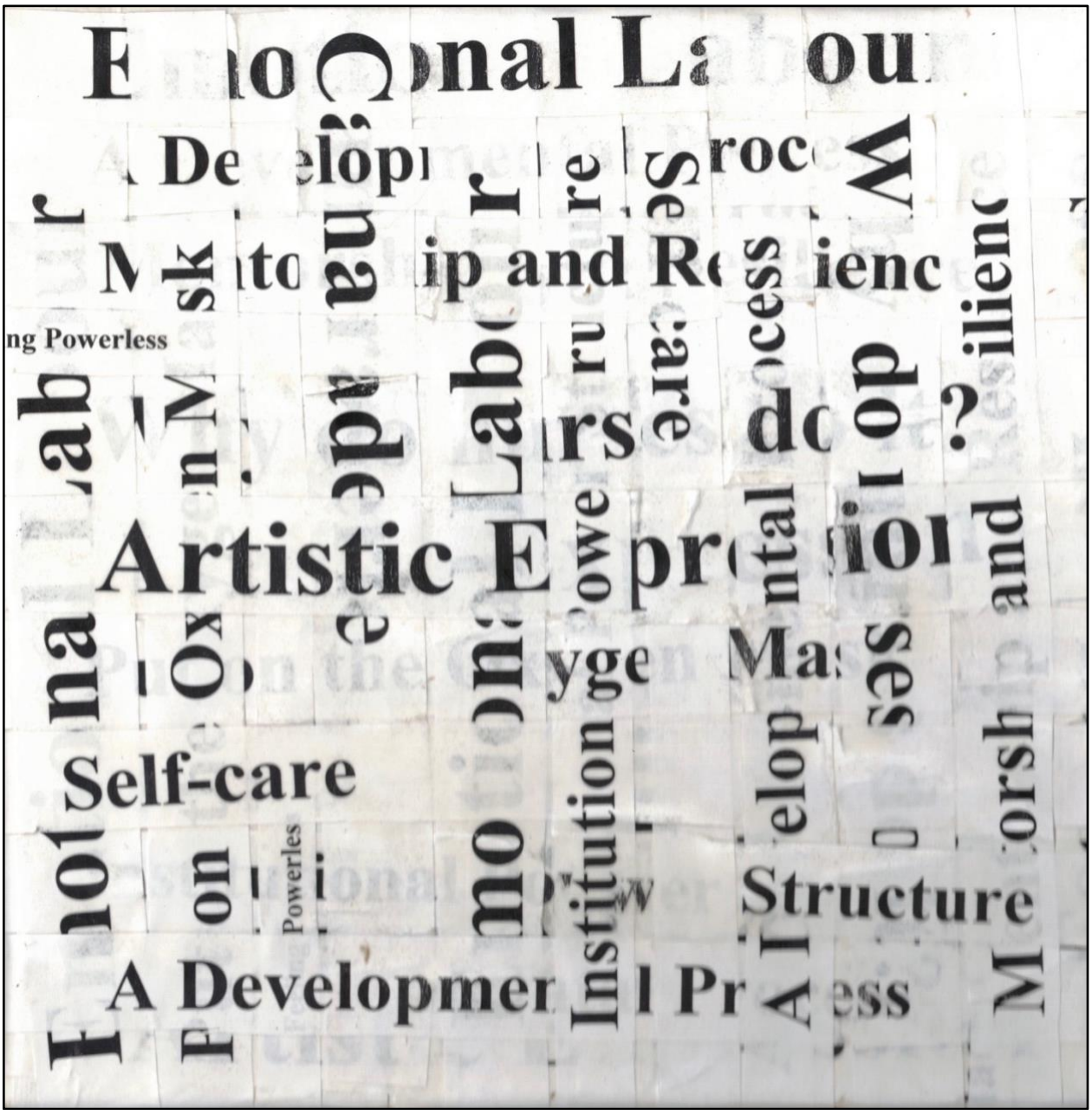
In this chapter, I have shared the common threads woven together in the midst of experiences as shared with the research participants. I was honoured to bear witness to the stories

told, and many of them will change how I look and feel about resilience because of the elegant and poignant ways they were shared.

Collage can be used in the inquiry process to express the subjective experience, encourage dialogue and storytelling among participants, or as an instrument for reflexivity (Butler-Kisber, 2018). I was drawn toward a textual weaving of the resonant threads evident in this narrative inquiry and expressed them in collage form. The collage I created intertwines my past as a textile designer and my present as a narrative inquirer weaving together resonant threads of nursing resilience. The way the layers presented themselves in this collage as transparent was not planned but fittingly occurred in happenstance and is a part of the collage that is most meaningful to me. This speaks to the layering of experience and is linked to the work of John Dewey; each experience contributes to the next one. Something else that happened by accident but is fascinating is how the textual expression “feeling powerless” in small font presented itself so prominently, although it was randomly designed. See figure 6 for this collage which expresses the resonant threads woven together from this narrative inquiry.

Figure 6.

Resonant Threads Paper Weaving



Chapter 7 Contributions to Theory

Clandinin (2013) noted that, at the outset of a narrative inquiry, the researcher must justify their reasons and consider the “so what” and “who cares” aspects of the research puzzle. It is essential to reach the point in a dissertation where the author can outline how the research they have embarked upon contributes to and deepens knowledge and understanding; this chapter will review the findings of this research and how they relate to the literature to date on nursing resilience. This chapter will feature contributions to the literature on nursing leadership and feminism, feeling valued, artistic expression, the benefits of collaboration, mentorship, and pedagogical shifts in nursing education to support resilience. Also discussed is the media’s prominent narrative that nurses' main concern is compensation.

Nursing and Feminism

Nursing exists within a power structure in healthcare that has persisted since nursing first grew out of a need for nurses to work in military hospitals (Eliason, 2017). This research was underpinned by a feminist lens which was a framework that critically assessed the inherent power dynamics in the stories the research participants shared. This research highlighted that the research participants align philosophically with feminism and the caring part of the profession but feel dominated and voiceless within the healthcare institution. This research will add to the literature on nursing, nursing leadership, and healthcare's power structure.

Nursing is fundamentally female-led and employed, yet it does not represent a profession where women always support other women. In the literature, authors like Chinn and Wheeler (1985) and Welch (2011) advised that adopting feminism in nursing might help establish the nurse as empowered. Friend and Sieloff (2018) studied the topic of oppression and nursing. They recommended nursing empowerment as the key to freedom from oppression gained through

control over the work environment and autonomy as a profession. Even though these authors envision an empowered and autonomous nurse, the healthcare institution remains an oppressive and dominating presence. This research has shown the detrimental impact this phenomenon has on nursing resilience. It would seem natural that women in leadership would identify with a female workforce, but as exposed in this research, the opposite of this is noted. In the stories shared by the research participants, some feel dominated and controlled in their workplaces.

Emily noted that her husband's workplace in a municipal portfolio supports and encourages him to stay home with his young children when they are sick. Christine said she had a similar experience with her husband's workplace, enabling him to take as much time off as needed when their children were sick. Neither Christine nor Emily felt they had been supported by their nurse leaders when faced with parenting challenges like managing sick children at home.

I have seen a young nurse colleague have her pay cheque or her vacation time reduced if she was a few minutes late for work, even if the reason for this was that her child's school bus was late. I have also seen many nurse colleagues reduced to tears because they had been reprimanded by the nurse manager if they thought they were taking too much time off work with sick children.

Literature exposing the impact of nurse manager behaviours on nursing resilience by authors like Cara (2011), Putra et al. (2021) and Ashley et al. (2021) determined that the caring behaviours of the nurse manager cultivated a positive and caring working environment and positively impacted nursing resilience. The literature also noted a benefit for patient care; nurses who feel valued and cared for give better care, and patients feel better cared for. Boykin et al. (2021) looked at nursing leadership during the pandemic and found that the more commitment

that nurse leaders show to coming to know what matters to patients, families and staff, the more that practice is transformed; nurses have increased levels of job satisfaction.

Raso (2020) stated that a positive working environment with caring and authentic nursing leadership responsible for shared decision-making, collaboration and recognition supports resilience. She says there is a relationship between resilience and the work environment, and nursing resilience will not be improved unless there is a change in the work environment.

The research participants noted conclusively in this study that it made a difference if they had a manager who supported and held a genuine interest in them as valuable team members. Emily noted this in her narrative story when, even though her work was stressful, she felt empowered by her manager. She felt respected for her knowledge and experience, and she was supported when needed. She appreciated how her nursing manager trusted her. This was also elucidated by Anne, who, after experiencing a new nurse manager, realized how much more empowered she felt when she had a nurse manager who supported her and showed that she cared about her. She also noted how much more she could accomplish at work, knowing there was inherent management support.

Anne, Ella and Christine all had experiences where they felt unsupported by their nurse managers, who they felt lacked a caring personality within a caring profession. Ella noted how she felt insignificant to her manager. Christine said that, even though she valued her own experience and judgment, she felt that her nurse manager looked at her as a faceless employee who would be easily replaceable. The impact of feeling this way and how this impacts nursing resilience cannot be understated. Ella stated that, at this point in her career, she wants to resign from her nursing position as soon as possible because she has found it impossible to stay within the current working environment.

The research participants in this study noted that decisions made without collaboration and input from nurses working the frontline during COVID-19 were devaluing. The research participants all shared that they felt they should have been consulted more in the decisions made about managing this public health crisis. They stated how debilitating it was to be led by new nurse graduates who acted as their charge nurses in the testing and clinic environments and how hard it was to watch the inexperienced choices they made with no input. It is reasonable to say that this led to an unsafe practice setting in an already stressful situation.

Early in my career, nurses stood when doctors, who were mostly men, entered the room; doctors were not accustomed to policy challenges, as evidenced in the narrative account I shared called “Get me a nurse who will.” In the literature, a common theme is that nursing began with a subservient and subordinate relationship (Fowler, 2017). The male dominance hierarchy in society was transferred to the doctor-nurse relationship with the same male authority order (Choperena & Fairman, 2018). According to Tayray (2009), nursing is a fundamentally gendered institution embodied within a patriarchal healthcare system and culture.

Interestingly, in the current healthcare context, the research participants reported that doctors now tend to defer to nurses more and that nurses are respected for their knowledge and experience in healthcare. Ella and Christine shared stories supporting this from their backgrounds working in various healthcare sites. Christine believed that doctors have realized that nurses are integral to their work and see them more as equals. Christine commented on this shift in dominance in healthcare; now, nursing is dominated and controlled by nurse managers, and nurses continue to be marginalized and oppressed.

Nurse managers in positions of power dominate the predominantly female nursing profession; the research participants wondered why nurse managers tended to manage from a

place of dominance and control. Christine talked about an awareness of the power structure in healthcare based on her interactions with her nurse managers. Emily wondered why nurse managers express their power and authority over nurses in anger.

Emily, Ella, Christine, and Anne all shared stories of when they had felt valued in their roles by either the medical staff or nursing management. They also shared how much this positively impacted their efforts at work and their feelings of being connected to their work. The research participants also shared how feeling that they were not valued by nursing management has led to feeling insignificant within the healthcare institution. Stillwell (2019) stated that there is an inference by politicians and health leadership that nurses are a disposable resource that can easily be replaced. According to Stillwell, healthcare managers assume that there will always be more women to fill the gap in the nursing workforce. This idea intersects with the stories Ella and Christine shared; both felt they were not valued, and the nurse managers' actions made them feel that the nursing staff were easily replaceable. This also relates well to my experience of being dismissed from the last nursing job that I interviewed for. Ella noted that she felt a symbiotic benefit in the caring relationship between the nurse and the patient, which made staying in the profession advantageous. She pointed out that after feeling devalued and dehumanized during the pandemic, the benefit of identifying with caring is not enough to keep her in the profession. As a result, she wants to leave as soon as possible.

This research adds to the literature on the impact of the power structure on nurses and how it impacts nursing resilience; sharing the stories of the research participants has highlighted how important it is to make positive changes to minimize the impact that the power structure has on nursing. Power and dominance over nurses in the healthcare institution date to the Crimean War, so a solution to it is complex. This research has highlighted an important starting point:

nurses must feel that the healthcare institution values them and that they are vital to the healthcare team. Managers' supportive and caring behaviours and a collaborative work environment positively impact resilience, and the nurse feels more empowered in their work.

Benefits of Collaboration

The benefits of being a part of a collective experience have been an essential conclusion of this research study. The importance of nurses feeling like crucial members of a team has been noted in the literature (Clancy et al., 2020; Vázquez-Calatayud et al., 2022). This research study shows how the participants felt they needed their team members and how the lack of a team atmosphere impacted their resilience.

Ella noted that she would cry in the car on her way to work during the pandemic because she was always working at different sites and with other nurses. Ella questioned if there was a conscious effort to split up teams during the pandemic as an expression of dominance. Christine stated that constantly being moved to various locations where she did not know anyone was difficult. One nurse I know tried to develop a team atmosphere at one of the testing centres, like positive affirmations on bulletin boards to encourage staff; she was admonished by the nursing manager and told to stop; she was told that was not her job. In contrast, Emily noted her positive experiences in the collaborative team atmosphere she developed with nurses doing similar work across the country. The positive benefits of a team atmosphere toward developing nursing resilience cannot be underemphasized.

The literature notes the positive impact of collaborative research on both the researcher and the research participants (Cole, 2006). This research has exposed the benefit of the relationships created by this research group which positively impacted the research participants. This was achieved by the creation of an environment that encouraged discussion. Another added

positive element of this research was the result of the design and viewing of other research participants' art. As a result, the nurses understood that they were not alone in how they felt about work during the COVID-19 pandemic. Being a part of this research brought them peace and was therapeutic because it helped them to be able to process their feelings. As a researcher, I expected the art creation process to be therapeutic as art has been used in therapy. Leavy (2018) supported this in the literature. I did not anticipate, however, how similar the symbolism chosen in their collages would be; this added to the positive benefits of a collective experience.

The power of story in narrative inquiry has been acknowledged in the literature on the topic (Connelly & Clandinin, 2006; Wang & Geale, 2015). This research has demonstrated this through the powerful stories shared and the images created. The healing nature of storytelling was revealed, contributing to the literature on this topic.

I received an email from Ella after she reviewed the interim texts, and I remember thinking that I had underestimated the research's carryover impact on the research participants. I share her email here and noted that she stated that reading through all the texts reminded her of the shared value nurses have.

> *I just finished reading through the whole chapter; how powerful and impressive your work is. I loved reading through everyone's comments. Thank you for inviting me to be part of this process. You have brought me peace and reminded me of our shared value as nurses ♡ We are damned important! And when we stand together and support each other, anything is possible!*

Christine shared that she also found that being involved in this research has energized and healed her. Christine stated this:

> *It is excellent! I am grateful for how being a part of this has been so therapeutic, which is in your threads. I feel that there are so many possible solutions that could support nurses' resiliency when we are not powerless and incorporated in decision making.*
> *I feel very uplifted.....*

As a researcher, I also want to emphasize the degree to which I benefitted from sharing my stories about nursing resilience and being a part of this research as I entered into it in the midst. I also found peace from the negative experiences I endured working during the pandemic as I became a part of this collective experience. This is a significant contribution to the literature and one from which we all benefitted.

Artistic Expression

Themes noted in the literature on the use of art in research include its capacity to make the invisible visible, to explain without words, and to show visually (Jarvis & Gouthro, 2015), its ability to form new knowledge (Eisner, 2008), and the potential to represent visually multiple realities (Leavy, 2018). The research participants shared how, by creating and viewing the art made, they understood that they had similar thoughts and feelings about nursing resilience, bringing them healing and peace. Ella shared that she enjoyed the collage creation and that not only did she find it cathartic but also that it was emotionally relieving to her. The art caused her to think and reflect on her feelings that she had not deeply considered. Butler-Kisber (2018) noted that collage creations could encourage unconscious thoughts to surface, facilitating thinking, talking, and writing. Anne enjoyed creating the collage because, in expressing her feelings about resilience, there was a carryover impact for the viewer, who could see what she had expressed in her art. The collages made the invisible visible from multiple subjective realities.

Gray et al. (2015) concluded that arts-based research approaches aligned with feminist analysis because both disrupt dominant social discourses that marginalize and silence women. With a feminist lens on the issue of nursing oppression, the research participants were able to give voice to their feelings of powerlessness within the healthcare institution. This essential

contribution to the literature underscores how the arts give voice to the silenced. The images produced by the research participants expressed how it was to work within healthcare from their perspective at this time in history. As Anne described it, the art will live on to inform the future about what we went through at this time. This is a significant and powerful visual contribution for generations of nurses in the future who might wonder what it was like to work during the pandemic.

Mentorship

In the context of nursing education and support for new nursing graduates, the literature has recommended that mentorship does help nurses transition from nursing education to graduate nurse practice. Dewey (1916) thought that by doing, learning results naturally, and this concept connects philosophically with the idea of mentorship.

Mijares and Radovich (2020) indicated that mentorship in nursing needs to be seen as an extended relationship between mentor and mentee, which is long-standing and supportive to best support resilience. Mentors in nursing often find themselves unable to wholly support their nursing proteges because they are already struggling to keep up with conflicting demands at work. Literature like Nowell et al. (2017) noted that fewer than 35% of healthcare sites support formal mentorship programs in nursing.

Mentorship in nursing has not been the experience of the research participants in this research, even though it is supported and encouraged in the nursing literature. The research participants in this study noted how positive they see the relationship between mentorship and nursing. Emily stated that she wondered why mentorship is not promoted more in nursing; she asked if this was linked to the idea that nurses are expected to be self-sufficient. Once a nurse

passes their exams, there is an expectation that they should be able to function on their own. She feels that mentorship is seen as a "dirty word in nursing."

Anne felt that if she had experienced a mentor to help guide her in her first nursing job, she might have stayed in the medical unit where she was first employed. She thinks that if she had not found nursing work outside the public system, she probably would have resigned from her nursing position and nursing permanently. Christine had the good fortune of being mentored by her mother, a nurse who helped her learn to navigate working as a nurse in her developing years. Christine is committed to informally supporting new staff because she understands it is crucial in developing new nursing graduates.

John Dewey believed that education should be a process of living and not a preparation for a future living (Hinchey, 2019). Anne said you cannot see and touch resilience; you must live it. This is a vital lens through which to consider resilience; what better way to influence resilience than to support its growth through mentorship in nursing education?

The literature has indicated that there needs to be a commitment by the institution and nurse managers to support nurse mentorship in a formal, sustained, and meaningful way. Maintaining resilience is critical in the first years following graduation because some estimate that 33.5 % of new nursing graduates leave the field within two years of graduation (Draper-Lowe, 2016). Çamveren et al. (2020) stated that new graduate nurses are more likely to leave the workforce, especially in the first year, which they conclude is due to a lack of support from managers and colleagues during their transition period from student to graduate. There must be a challenge to the idea that new nurses must be independent, rugged, and resilient individuals. They must be supported in the workplace, an essential contribution to which this research has called attention.

The research participants in this study all felt that resilience is part of a developmental process; this points to the need for more formal mentorship programs that need to start in nursing education. This aligns with John Dewey's (1938) theory of education gained through experience, each experience building the foundation for the next. This is an essential conclusion of this research and needs to be addressed to support nursing students. More qualitative research on the impact on resilience where formal mentorship programs were introduced would be warranted.

Nursing Education

One of the critical aspects of this research was understanding the extent to which the research participants learned about nursing resilience in their experiences as student nurses. Emily recalled some discussion in her nursing education about nursing resilience; however, none of the other nurses in this research shared the same experience. Resilience needs to be a topic that is discussed, and there needs to be more emphasis on it in nursing education.

The idea that poor resilience is a deficit in the individual nurse is concerning because staffing levels continue to drop despite increasing acuity levels. If a nurse is not resilient, it is typically seen as the nurse's fault, not the system (Conolly et al., 2023; Taylor, 2019; Traynor, 2019). Suslovic and Lett (2023) added that nursing is a fundamentally oppressed group and that resilience "treatment programs" point to individual-level interventions in response to systemic contamination. These authors affirmed that nurses heal from structural attacks to resilience rather than adjusting to it. Nursing resilience must be addressed collectively and systemically, not solely individually. This research shared stories about stressful times that the nurses experienced: Emily shared a story about the first death she experienced, and Ella shared a story about worrying that her patient might die. I shared painful memories from my experiences as a nurse. An individual in a caring profession will have emotional stressors to contend with. We must

educate nursing students to prepare them for emotional stressors but also consider how resilience can be addressed collectively. This would be an essential consideration for future research on nursing resilience.

Thoughts about nursing education and resilience have been a topic that I have returned to as this study has unfolded. Indeed, this study and my shift into academia have caused me to pause and think about how we could approach nursing resilience differently in education.

I noted some concerns about how we educate nursing students during some personal reflection after a nursing class I recently taught. I was hired as an adjunct nursing faculty lecturer for a public health nursing theory class at a prominent east coast university. The course was held online, and attendance in class was not compulsory, but participation with an online discussion board and completing three projects were required. As a Ph.D. student, I had attended online courses before and was familiar with this educational delivery system.

I incorporated adult learning principles into my teaching through small group work, arts-based teaching methods and an active participatory philosophy. The students who attended the recorded lecture were not motivated to discuss the concepts introduced, even though I created and supported a safe space to do so. There was adequate attendance to my lectures, but most of my encouragement to develop active dialogue was met with silence. This was a fourth-year class; the students had one semester left to complete their nursing degree. I wondered why these students declined to engage in class; I noted active discussion in the mandatory online discussion board but little discourse during the in-person portion of my course. I noted interest in dialogue only when the students had questions about how to approach the assignments.

I reflected on what I could have done differently. As I reflected on this experience, I wondered if these students had not attended a class like mine where a more learner-centred

philosophy was utilized. As a nursing student in the 1980s and when I completed my bachelor's in nursing degree in 2008, I experienced, in the words of Paulo Freire (2000), a banking style of education. I was tasked with memorizing information; testing days were spent completing multiple choice exams in an allotted time period.

I felt like the students I was teaching in the class were solely interested in memorizing content and preparing for projects. The students were not used to a teaching style that encouraged discussion about the foundational ethics of nursing. This experience and working through this dissertation have led me to wonder if we need to change the way we, as educators, approach nursing education. Students should become active participants in their education; they should feel empowered and experience a democratic education where they feel encouraged to be fully engaged; perhaps this might lead to a nurse who feels more connected, actively engaged, and influential in a profession that has been marginalized and oppressed. Paulo Freire (2000) thought that when education is used as a form of self-development instead of a memory test, the student realizes that knowledge is power. This might also impact longevity and resilience in the profession because the student sees themselves as empowered.

The arts application and use in nursing education is a concept that must be considered more seriously. The research participants shared that, after the arts-based collage creation, they understood that they were not alone in how they felt about nursing resilience. Using the arts to support learning and understanding has been a contribution that this research has added to the literature. This research shows the therapeutic and cathartic ways that art has helped the research participants find peace: arts use in nursing education needs to be more prevalent because of these positive benefits.

The benefits of using art to be attentive to the subjective experience of others could be applied to a wide variety of nursing educational curricula. In the literature, Rieger et al. (2020) have researched an arts-based pedagogy in nursing education in Canada. They found that art was an effective catalyst for learning about empathy, self-awareness, and reflection and fostered a more profound understanding in nursing students. These authors noted that the arts allowed for connection to and expressing feelings that were difficult to uncover. Obara et al. (2022) suggested that an arts-based pedagogy in nursing education enhanced critical thinking, learner engagement and group connections. Eisner (2008) stated that art can be used to improve the understanding of the human condition, making more expressive realities that may otherwise remain unknown. All of this suggests that using art in nursing education would be compelling for learning in both the cognitive and affective realms. More research is needed on using the arts in nursing to promote learning and processing complex thoughts and feelings and their impact on nursing resilience.

Emotional Labour

This research began by exploring Hochschild's (1983; 2012) theory about the impact of emotional labour where the outward articulation of emotion is not encouraged. There has been discussion in the literature about this by authors like Delgado et al. (2017), Załuski and Makara-Studzińska (2018) and Van Zyl and Noonan (2018), but little qualitative research on the topic and the impact of it on nursing resilience.

Emotional labour is something that nurses experience in their work; the research participants overwhelmingly articulated this. This is also echoed in the literature by such authors as Traynor (2019). Only Emily felt that a nursing instructor encouraged her to show her feelings after she experienced her first death as a student nurse. Emily shared that this experience has

helped her in her career because she felt that she had learned it was acceptable to share her emotions with her patients.

Emotional labour spent by healthcare workers is not widely accepted as harming resilience and so has not attracted special training to help healthcare professionals to cope with it (Załuski et al., 2018). This research has shown that nurses need more support to share with others, colleagues, and nurse managers. If they are struggling, sharing these thoughts and feelings should be encouraged. It must be underscored that sharing these thoughts and feelings does not indicate that you are weak; it means you are a human. Anne thought that healthcare employees do not show their emotions because they fear they will be assumed to be weak. Emotional labour spent needs to be accepted for its negative impact on resilience.

We must be caring toward each other. The idea that nurses do not need support to deal with the painful things they bear witness to needs to be addressed. As described by Ella and Christine, having nurse managers who merely cite vacation as a prescription to a nurse who says they are struggling is grossly misinterpreting a painful situation. This research has shared that the research participants have felt, at times, that they were not supported by their nurse managers when they were struggling. We need to do all we can as a profession to encourage and support nurses to remain by making them feel supported and encouraged to be there.

It Is Not About the Money

The media has contributed to the idea that the retention of nurses comes down to issues about money (Lale, 2021; Lee, 2021). As evidenced by the research participants in this study, retention and resilience are related more to respect and feeling valued within the leadership of the healthcare institution and the politicians that govern it. There needs to be more concern for respecting and valuing nurses for their commitment and experience. This research showed that

feeling valued does positively impact nursing resilience. The narrative that nurses work only for financial gain is inaccurate because the subject is much more complex and nuanced. This narrative needs to be modified, so nurses can appreciate their value. The media plays a large role and could help to change the lens that the world views nurses.

Self-Efficacy and Self-Care

Nurses need to care for themselves; this is underscored in the literature on the topic (Andrews et al., 2020; Clancy et al., 2020; Mills et al., 2021; Nilsson, 2022). Wei (2019) called for institutional support to encourage nurses' self-care strategies to maintain resilience.

Research participants in this study all practiced self-care strategies to help them deal with work stressors. Christine noted that nurses have been encouraged as a profession to care for others but that there has been little emphasis on the importance of caring for themselves. She thinks that nurses should be encouraged to care for themselves first to be better equipped to care for others. This concept has been missing in nursing up to this point. Christine eloquently shared that nurses must first consider placing the oxygen mask on themselves to be better prepared to help others. This is supported by the literature by Backer and Ulibarri (2021), who also suggested that nurses must care for themselves. These authors stated that nurses must put the oxygen mask on themselves first, the same metaphor Christine used. Christine feels that she has experienced nurse managers who do not promote the idea of self-care and that this negatively impacts resiliency. This is also noted in recent literature like Badu (2020), who noted that, in addition to individual resiliency interventions like self-efficacy and positive thinking, there also needs to be a commitment by the institution to support both formal and informal resiliency through leadership and role modelling.

Ella, Emily, and Anne all noted that they adopted strategies for self-care like physical activity, gardening, and close family connections to help them deal with stressors during the pandemic. Anne stated that as she has aged, she has realized through her experience that self-care is a priority in her life and that she puts that above all else.

Self-efficacy is the idea that one can overcome stressors and has been noted in nursing education literature as key to maintaining resilience (Hughes et al., 2021). Anne talked about self-efficacy related to the COVID-19 pandemic and stressed that this idea was one thing that helped her. She could envision a time when she would again be living in a world free of the impacts of COVID-19 on health. I also believed this idea related to the pandemic; I knew that, eventually, this would pass. Historically, the Spanish flu had passed, and the world returned to normalcy. This positive outlook and its impact on resilience is a contribution that this research study has highlighted and would warrant further research into cultivating this philosophical position.

At the close of this chapter, I have revealed the significant contributions this research has uncovered in this dissertation. This research has contributed to nursing resilience research and demonstrated the importance of nurse manager behaviours, their power over nurses, and their impact on nursing resilience. Nurses need to be valued and appreciated for their work; this research has exposed how this is not necessarily the case in healthcare and the consequence this has had on the nurses in this study.

This research has shown the powerful benefit of a collaborative atmosphere and the positive experiences felt by creating and viewing other participants' artistic collage creations. This was an exceeding highlight for me as a researcher, and as someone who had worked alongside the research participants, I related to the images created personally.

More attention must be paid to sustained mentorship, self-care, self-efficacy, and emotional labour related to nursing resilience. The focus in the media should be on more relevant issues that affect resilience than a focus on money.

Chapter 8 Reflections, Subjectivity, and Implications

Reflections

In this dissertation, I outlined why this research on nursing resilience was essential since the nursing shortage and loss due to attrition is a stark reality with which healthcare must come to terms. Within the context of my start in this Ph.D. program in 2019, the world was pre-pandemic; there was some concern for nursing resilience within the profession but not on a global scale as it is today. The pandemic has exacerbated the fears about nursing resilience as nurses globally respond to the stressors caused by COVID-19.

As the pandemic began, my focus for this dissertation shifted to a study on nursing resilience within the context of the COVID-19 pandemic. My working context changed to public health in 2020, and I was launched into working in response to the pandemic. With this alteration in my work environment, my interest shifted to thoughts about nursing resilience during the COVID-19 pandemic.

I have shared the resilience stories of four nurses who were redeployed during the pandemic. An essential aspect of this feminist narrative inquiry was the visual expressions of the research participants' stories of nursing resilience. By sharing the stories of these inspiring and influential women, I hope their stories will help inform best practices in nursing education and support nurse resilience within the healthcare institution.

In Chapter 1, I introduced my interest in nursing resilience and why it is essential for society in general. The resilience research to date has focused on reviews of past research, and there is a scarcity of qualitative research on the topic, which has informed how I approached this study.

In Chapter 2, I reflected on my narrative beginnings, my justifications for this research and my positionality. I shared stories that informed my nursing resilience because this is an essential landmark in narrative inquiry and represents a starting point. I shared links to Dewey's (1938) theory which described experience building upon experience and how my father's love for education impacted my perspective on education and learning.

In Chapter 3, I reviewed the literature on nursing resilience, professional identity, emotional labour and links to subservience and feminism. I presented literature examining the importance of mentorship, self-care, and recent literature on nursing resilience during the pandemic.

In Chapter 4, I discussed narrative inquiry, arts-based research, and the feminist theoretical framework, which provided the background for this dissertation. I reviewed the research design for this study, data analysis, and ethical considerations.

In Chapter 5, I shared the stories of the four research participants; these brave and powerful women had many important and meaningful stories to share about their experiences working during the pandemic and their stories of nursing resilience. I appreciated the stories and candour with which they shared them. They allowed me into private thoughts and feelings about nursing resilience as I shared my own stories. Their stories were even more poignant because I know that nurses are not encouraged to have a voice within the healthcare institution. Indeed, having agency is not encouraged by this authority. The research participants were open and disclosing because their anonymity was protected; this opportunity added to the unburdened sharing of their deepest thoughts and reflections.

Entering a trusting relationship with the research participants also contributed to the thick and rich descriptions of their experiences. Some of the most significant parts of this chapter

included the research participants' collage creations and artist statements. Images hold a deeper place in the brain, and these images have become deeply embedded into mine. Christine's bent tree and staircase and textual reference to the word history; Emily's poignant number 49, representing the lives of 49 people lost in two months and her description of crying in the shower to help her cope with the magnitude of the stress she felt; Ella's images of the black cloud and what that meant to her as she told her story about the nightmares she started having during the pandemic; Anne's images of family, relationships and food showed me that there were positive things that came out of going through this pandemic and how meaningful small random acts of kindness can be.

In Chapter 6, I shared the resonant threads co-composed with the research participants about their nursing resilience stories. Stories shared were within the context of the pandemic and in their past and present and will contribute to their future. The resonant threads included emotional labour, the black cloud, the institutional power structure and feelings of powerlessness, camaraderie, mentorship, resilience as a developmental process, why nurses care, self-care, and their thoughts on using an artistic expression in this research. These stories are both commanding and influential and will help add to the knowledge about nursing resilience that currently exists. These stories also give voice to the nurses who shared their frustrations about feeling powerless, and some strategies they found helped to maintain their resilience.

In Chapter 7, I shared connections between this research and the literature on the topic of resilience. Meaningful connections included the impact of power and dominance on nursing, particularly feeling unvalued and unsupported by nursing management, and the benefits of collaboration, a team atmosphere at work and in research, and the development of mentorship programs for new graduates. Connections are drawn toward a shift in nursing education toward a

more Deweyan philosophy of experience as an education and the potential of incorporating an arts-based pedagogy in the nursing curriculum.

In this final chapter, I pose a series of questions about where changes might be made regarding resilience within the institution and nursing education, subjectivity, and implications for further research on nursing resilience that have been brought to light as a result of this research.

Clandinin (2013) stated that narrative inquiries conclude still in the midst of living and telling, re-telling and re-living, the stories of experience that make up the inquirers and participants' lives, individual and social. As I write this conclusion and think about the stories shared with me by the participants, I feel honoured to be trusted with their innermost thoughts and feelings. I am privileged to have been allowed to give voice to their stories of nursing resilience. As a narrative inquirer, I continue to have long-term relational responsibilities to the participants in this research. I share this excerpt from my reflexive journal:

> *For nurses to break the silence about how the institution manages and directs them can be considered dangerous-the participants are brave and honourable for doing so and being frank about their thoughts and feelings.*

I often found myself thinking about nursing resilience and reminding myself of the purpose of this research. I returned to my reasons for utilizing arts-based research and, as Wang and Geale (2015) noted, found that it uncovered nuance and detail in a rich and meaningful way.

The nature of this research showed the importance of sharing and discussion and a collective experience between and among the research participants. Not only was the storytelling important, but this act also promoted healing. Wang and Geale (2015) stated that storytelling allows a moment for discussion and reflection, and I saw this portrayed repeatedly in this

research. Also, there were essential linkages made about the importance of mentorship and resilience in nursing.

The presupposition that nurses need to do more with less came from this research and is also shared in the literature (National Academies of Sciences, Engineering and Medicine, 2019; Traynor, 2019). This needs to be addressed to improve retention and balance for nurses. Nursing resilience must be addressed from a systemic level and not seen as an individual deficit. This fact is even more critical as nursing moves past the exhaustive pandemic stage and into a post-pandemic phase which sees many nurses exhausted and thinking about career changes.

I have reflected on the online format for this research, necessitated by pandemic public health recommendations restricting in-person meetings. I recalled feeling worried about the impact of this format on the artistic collage creation and on developing relationships with the research participants. This format effectively managed this type of meeting; eliminating the need to travel made meetings more accessible, and the group developed effective and influential personal connections even though they had only met online.

Subjectivity

My insider status as a nurse who worked in public health during the pandemic underscored the subjective nature of this research, as I shared many of the same experiences the research participants discussed. As subjectivity is an inherent quality of all qualitative research, that must be made explicit, I sought to monitor my subjectivity through my reflexive journal and my commitment to a focus on their stories. In addition, I created a sizeable reflexive landscape painting that helped me work through the impact of the emotional stories shared. This painting, a graduation present for my youngest son, now graces the walls of his clinic, where his patients can enjoy the scenery of the Rocky Mountains, I live close to.

This research was approached with a feminist lens, with gender at the centre of the investigation. Feminist ethics were at the foundation of how I approached the research participants and how I paid close attention to what they said. I was cognizant of protecting the research participant's anonymity because of the influence that power and control by the healthcare institution have on them, which limits their voice. Without the promise of anonymity, it would have been difficult to recruit participants to this research study. Although there may indeed be counternarratives, I was careful to note that these are the stories of the research participants, and I shared them in the way they were shared with me.

Implications for Further Research

This dissertation has highlighted several areas that could be advantageous in developing nursing resilience. The purpose of this research was to gain an understanding of nursing resilience and how best to foster and nurture it from an educational perspective. Changes must be adopted in nursing education and the healthcare institution to support nursing resilience. The implications of this research which I pose as questions, fall into three areas: research on the importance of feeling valued, mentorship, self-care and self-efficacy, and a shift in nursing education toward a more actively engaging and empowering pedagogy.

Viewing nursing resilience with a feminist lens has given great insight into the influence of dominance and control on nursing resilience and will inform further research on the topic; this research has helped to address the lack of qualitative research on nursing resilience within the context of the COVID-19 pandemic. Other implications from this research point to how important it is that nurses feel valued by the healthcare institution and nursing leadership. This research has uncovered concerning stories about how nurses in this research study feel powerless, undervalued, disposable and faceless and how this negatively impacts their resilience.

More qualitative research is needed to examine the benefits of mentorship in nursing education. According to Nowell (2017), it is only utilized in a small percentage of workplaces. Will the healthcare institution support the ongoing mentorship of new graduates in a sustained and meaningful way to support resilience?

The importance of self-care and self-efficacy to support resilience was recognized in this research by the research participants. Nurses are known to have the poorest health of any occupational group, according to the American Nursing Association (2016). How can nurses be supported to care for themselves? Christine shared that, as nurses, we need to remember to put the oxygen mask on ourselves first, and there needs to be a commitment by the institution to support this.

In nursing education, would a shift toward a more learner-centred pedagogy support a learner who feels encouraged to be fully engaged? Would this lead to a nurse who feels more connected, actively engaged, and influential in a marginalized and oppressed profession? If students were encouraged to become active members in their education, would this lead to a nurse who understands theory in addition to learning it, feels more closely aligned with caring and knows how to assess their learning critically? Would a shift to a more Deweyan and participatory style of education achieve this?

This research has shown how the arts are cathartic and healing when dealing with stressful experiences and how the arts connect the cognitive with the affective. Could nursing educators utilize an arts-based pedagogy in nursing education to support learning that combines the science of nursing with the art of nursing, making linkages between the cognitive and affective realms of experience? Obara et al. (2022) suggested that an arts-based pedagogy in

nursing education enhanced student engagement, group connectivity, social emotional learning and critical thinking. Is this something that could be broadly implemented in nursing education?

This research has demonstrated the healing nature of arts-based approaches in nurses who were processing their experiences about nursing resilience during the pandemic. The use of art as a source of healing and reflection is well documented in the literature (Leavy, 2018) and reinforced in this dissertation and the stories shared by the research participants. This research has additionally highlighted the impact of the group effect that this group of nurses developed in this research resulting in them feeling that they were not alone.

This research gave voice to stories of nurses' resilience. Could some of its findings inform how changes can be made in nursing education and the healthcare institution? Nursing is a vital resource in health care; however, it faces extinction due to attrition and burnout (Draper-Lowe, 2016). Çamveren et al. (2020) stated that new graduate nurses are more likely to leave the workforce, especially in the first year. Why is resilience not a topic of concern being addressed in nursing education and the healthcare institution?

This research study significantly contributes to the current understanding of nursing resilience from a resilient nurse's perspective, which is missing in recent educational research. It is a study of nurses' stories of resilience, which is essential to share from an academic standpoint because their experiences are often untold; these nurses' stories are important. Wang and Geale (2015) noted that when narrative inquiry and arts-based research combine, previous experiences uncover nuance and detail in the stories. These approaches added to the thick and rich detail of the nurses' stories of resilience in the context of the COVID-19 pandemic. It was crucial to undertake this study on nursing resilience because of the vital place nursing holds in health care

and the current concern around nursing shortages due to attrition. Can we risk the loss of more nurses?

As I reflect on this dissertation, this relationship that I have entered into in the midst has helped heal me and brought me peace. As I moved in and out of the stories shared, there was a healing carryover impact on me that I had not anticipated. The relationships developed in this research will be close and long-lasting as we plan to stay connected now that this research is complete. As I moved into this relationship, this collective experience gave voice to the voiceless and power to the powerless. It showed the importance of listening to the stories of women working within a marginalized profession. This dissertation is an accomplishment, but more importantly, it represents a path toward my healing. This was a challenging experience as a researcher because I was an insider and had similar experiences working during the pandemic. I hope the future sees nurses feeling valued, respected, and essential and that the stories shared here will inform positive changes that will positively support nursing resilience.

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Appendix A: Letter of Invitation

Title: Understanding Nursing Resilience in Educational Research through Narrative and Art: A Feminist Exploration

Name of Researcher: Carol Flegg, Ph.D. (c), Mount Saint Vincent University, Halifax, Nova Scotia.

What is this research project about?

I am a Ph.D. candidate in Education at Mount Saint Vincent University, a part of the Nova Scotia Interuniversity Doctoral Program. As a part of the Ph.D. in Education Program, I am interested in exploring the experiences of nursing resilience in public health during the COVID-19 pandemic. This research will add to the growing literature on the importance of narrative and arts-based expression and inform existing knowledge on nursing resilience for educational purposes.

What will I be expected to do?

There will be 4–5 other nurses participating, and we will meet as a group for an introduction to the project and a discussion. Again, if the COVID-19 pandemic restrictions are still in place, all meetings will be held online. First, I will ask you to create a collage, which expresses some of your nursing resilience thoughts. This will take approximately 2 hours and I will supply you with artist materials to make your collage. You do not have to have artistic talent to create a collage; the collage is simply a way of beginning our discussion together. Once your collage is complete, I will ask you to write a statement that sums up your thoughts about the collage. Then, you will be asked to share your ideas with the group. With the permission of

individuals and the group as a whole, I will record the group discussion using a voice and video recorder to listen and view your answers again later. I will later have someone transcribe the interviews and group discussions from the audiotapes; they will sign a confidentiality agreement to keep all information confidential. I will also take notes on paper during the interviews and the group discussion. I will ask you to photograph the art piece you created and send me a digital image. At the end of our group session, I will ask you to record your thoughts about our session, about your art piece or your ideas about nursing resilience in a reflective journal. I will send copies of the digital images to the group so that we can discuss and analyze each of the collages created by the group in the second group session.

I will ask you to meet with me again for one-on-one interviews, the time and frequency of which we will negotiate with each other. Ideally, I would like to meet within 1 month of the group meeting and then again 2–3 times afterward, which I will negotiate with you. We will discuss the art piece, your artist statement, and your reflective journal. During our one-on-one interviews, I'd like to talk to you about:

- How you define resilience.
- Your thoughts about nursing resilience and emotional labour.
- Moments in which you experienced resilience.
- Your thoughts about how you fostered and nurtured nursing resilience before and during the COVID-19 pandemic.
- Feminism has been defined as a movement focused on changing how people see male and female rights and campaigning for equal rights. Would you describe yourself as a feminist?
- Other comments on the topic.

How much time will it take?

The two group sessions will take a maximum of 2 hours. The one-on-one interviews will take about 1 hour. The group sessions and the one-to-one interviews will occur at an agreed upon location and time that works for you.

What if I don't want to participate or change my mind in the middle of the research?

Your participation is voluntary. You have the right to refuse any questions you do not feel comfortable with, and there will be no adverse consequences. It will not affect you or any other activities at Alberta Health Services. If you have agreed to have the interview recorded, you can ask me to turn off the voice recorder at any time during the interview. You can tell me if you want to stop. You will be able to review the transcripts, and anything you do not wish to be included will be removed. Process consent will be maintained throughout the research process to ensure that there is continued agreement about your participation in this research project; you can remove yourself from this research study at any time.

Are there any benefits to participating?

I hope you will enjoy having a chance to talk with other nurses about nursing resilience and learn different ways to express your experiences of nursing resilience through narrative and in new and creative arts-based ways. Your insights will add to the current knowledge base on nursing resilience.

Is there any harm to participating?

There are no known harms related to this research, and you can withdraw at any time. Because some group work is involved, your anonymity cannot be fully protected; other research participants will know you participated in the group project and understand what was discussed. The members of the group will be asked not to disclose the ideas or identities of others. The

recordings of the interviews will be kept in a locked place until the project is complete. The digital images will be saved for use in the research report and my dissertation; all audio and video recordings, journal reflections, field notes and transcripts will be destroyed. Your name and identity will not be used in the report, and your answers to interview questions will be kept confidential. Some parts of the discussion and interviews may be emotionally challenging as you recall difficult experiences related to working during the COVID-19 pandemic. Alberta Health Services Employee and Family Services contacts will be made available for you should you require them.

A research report outlining the findings will be available to you as an individual participant in the research if you ask for it. I will keep all the recordings, journal reflections, field notes and transcripts in a locked place until the project is complete. At that time, I will destroy them.

Where do I go if I have any questions?

If you have any questions about the research or anything I have said in this letter, you can contact me or my advisor at Mount Saint Vincent University by telephone or email.

Carol Flegg Ph.D. (c).	Dr. Ardra Cole Professor of Education

Thank you for considering my request. Signature of Researcher: _____

Date: _____

Appendix B: Participant Consent Form

Title: Understanding Nursing Resilience in Educational Research through Narrative and Art: A Feminist Exploration

Name of Researcher: Carol Flegg, Ph.D. (c) in Education, Mount Saint Vincent University

- I understand that Carol Flegg will facilitate the group session in which I will create a collage and participate in two group sessions that will include four–five other nurses. My art piece will be photographed, and the discussion will be both audio and video recorded. I will be given a reflective journal to record my thoughts about the activity and discussion and my nursing resilience thoughts.
- I understand that Carol Flegg and I will re-convene after the 2 group sessions for a one-on-one interview and again at 2-month and 6-month intervals after the arts-based session. I know that I will be asked questions like the ones outlined in the Letter of Invitation, and I can choose not to answer a question. Carol Flegg may be taking notes during the interview, and the discussion will be audio and video recorded. I can, however, ask Carol to turn off the voice recorder at any time. I understand that a research assistant will be utilized to help with the transcription of data. This person will sign a confidentiality agreement and will not share any aspects of the research data.
- I understand that a photo of my artwork, my ideas or words will be used in Carol's Ph.D. dissertation and subsequent publications and presentations. I may read and comment on the transcripts of the group sessions and my individual interviews. I understand that my name will not be used in publications on the study and that I will be identified with a pseudonym that I will choose.

- I understand what this research is about and agree to participate. My participation is voluntary, and I will not be paid. If I refuse, there will be no adverse consequences.
- I have received a copy of this consent form.

Signature of Participant: _____ Date: _____

Signature of Researcher: _____Date: _____

Appendix C: Participant Background Survey

1. Age _____?
2. Gender_____?
3. Highest level of Education_____?
4. How long have you been a community health nurse _____?
5. What year did you graduate from your Baccalaureate Nursing Program_____?
6. With what ethnicity do you identify _____?

Appendix D: Interview Questions

1. How would you express your personal story of nursing resilience?

- How do you define nursing resilience?
- How have you fostered/nurtured your nursing resilience?
- From your personal experiences of nursing resilience, do you believe that resilience can be taught? How would you suggest that it be taught?

2. In your role as a community health nurse during the COVID-19 pandemic, how would you describe your stories of nursing resilience?

- Can you describe times when your nursing resilience was tested?
- What impacted your resilience positively? Negatively?
- What barriers do you see in influencing the development of nursing resilience?

3. Emotional labour has been described in the literature as the management of feelings that fulfill the job's emotional requirements but may contrast how one feels emotionally. Have you experienced emotional labour in nursing?

- What impact does emotional labour have on your experience of nursing resilience?

How did you feel about our group session? About making the collage, about our discussion, or about writing in your journal?

- What did you like? Would you change anything?
- What did you learn as a result of what we've done so far? Has anything changed in your thinking about nursing resilience? If so, why?
- Can you see any ways that activities like these might be integrated into your professional learning to help you foster/nurture nursing resilience?

- Do you self-identify as a feminist?
- If so, why or why not? How would you define feminism?
- Do you think that power relations in health affect your ability to provide care? If so? Why, or why not?