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Preferred Realities in the Construction of Professional Identity for Nurses in Training

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Abstract: White & Epston (1991) state that people live their lives through stories. And these stories shape their lives through the real effects they have on them. So, we can say that talking in a certain way about what you are experiencing can build your reality by virtue of which you will act further. Behind the expression preferred reality is that part of the story life of a person which sustains what she likes about her. Opposite to preferred reality is the reality that tells about the person a story that she rejects and this can create a problematic context in her life. If we think about the professions that involve practice during training, we can understand the importance of the feedback that students often receive in practice from their teachers. The practice in the medical field, however, has a peculiarity, because the students receive another important feedback than the one from their teacher and it is the one from the patient that proved to be important for the students in nursing enrolled in this study and also one of the most important relationship brought into the conversations was the relationship with the patient with a specific dynamic of power.

Keywords: *preferred reality; preferred stories; professional identity.*

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1. Introduction

This article is trying to offer a constructionst approach to nurses' identity development during their training to became nurses and it is linked to the stories picked up from the clinical practice. How students in nursing are dealing with the stories they meet in the clinical practice can contribute to the way they see themselves as future nurses. Especially when it is about the feedback from their patients which seems to be so important in evaluating their abilities and skills in being in certain ways like a person and in being a nurse when they are making their first medical maneuvers.

The way the students „choose" the stories to remember from the clinical practice and the stories that are being told and retold to the others makes us wondering about what make them pick up some stories and forget others? Next to what they are told in the classrooms by their teachers about how a nurse should be and about how they, as learners, are dealing with medical techniques, the patients can give the students in nursing valuable descriptions about them during their clinical practice. And, the stories about the way the students are seen by the patients and about the way the patient felt being cared by the student in nursing seem to be important to them also. In this context some students seem to choose the stories which are preferred by leading them to what they would like to be as future nurses and which we could call „preferred identities" (Charmaz, 2006). This preferred identity built in the dynamic of the relationships that the students in nursing are involved in, during the clinical practice, completes and shapes their personal identity by creating links between their personal and professional life underlying some aspects and diminishing others.

2. Methodology

The aim of the study is to identify the dominant speeches in developing the professional identity for future nurses from the stories collected in the Narrative Medicine Program. During the clinical practice, the students met once a week for sharing stories that touched them. The students decided on the significance of the stories and not the facilitator so, the interview was addressing what students considered significant stories while they were having their clinical practice training. In this context the best way to analyze the data was considered to be Grounded Theory because it is based on the "progressive identification of semantic categories generated from the direct analysis of speeches" and their aggregation into a theory,

using various methods of data collection, including the interview. (Sandu, 2018).

The number of subjects at each group meeting varied according to their participation, which was voluntary. Groups of subjects ranged from 3 to 12 students per meeting, so the duration of interviews was also varying from 58 minutes to 120 minutes. The duration of the interview was also depending on the level of participants' involvement, the main concern being comforting the student, who had the freedom to answer or not the questions that he considered either too personal or too difficult to manage. There have been instances where outsider witnesses brought personal stories at the reflection stage and we can see this using the concept of "lost in story" used by Nell (as cited by Moriss et al., 2019) to describe the audience's involvement in the story. The opportunity to express the self-reflection after listening to the central story, has often captured the tendency of some of the audience to enter the role of the storyteller, making multiple connections with their own life history, which can confirm that the plot of the story has significantly touched the imagination of the witnesses in the position of a listener.

Given the structure of the program, some clarifications are needed on the particularities of data analysis that comes from the interviews. The Narrative Medicine Program, which is carried out according to the principles of the outsider witness practice, involves segmenting the data collection process into three stages. This is important in data analysis, due to the dynamics of the interview in the outsider witness practice.

Considering that each meeting, from the perspective of the narrative approach, involves going through the three steps, the analysis of the data can be divided according to these three stages of the interview, as follows:

1. speeches in the central story - the storyteller's interview
2. speeches that appeared in the retelling-reflection phase - witness interview
3. speeches that appeared in the re-telling phase. – re-interviewing the storyteller

This way of analysis can capture the process of constructing the story during the course of the interview, surprising what the narrative approach calls "enriching the story" of the central storyteller according to the feedback he receives from the participating witnesses, as well as "enriching the story" of the witnesses through the connections with their own stories and the reflections brought by the conversation between the facilitator and the central storyteller during the main interview of the meeting. What it will be analyzed in this article are only the speeches resulted

from the central stories and other aspects will be presented in future articles, because of the complexity of the analyzes.

This secondary analysis of the data collected from the Narrative Medicine Program is carried out using the Grounded Theory method, which will be applied to each of the 3 stages, resulting in categories of dominant speeches from the central storying, retelling and re-retelling phase in order to be able to track how speeches are constructed or accentuated during interviews, through the contribution of all participants. It is worth mentioning that the stories brought by the students in question which they consider significant are those aspects that they feel the need to tell and retell to their loved ones, and these interactions can participate in the construction of their own realities and visions of their future nursing profession.

3. Social construction of reality and professional identity

Antonio Sandu and Elena Unguru (2017) identified two theories sustaining the social construction of reality:

• The sociologic perspective of Berger and Luckman (2008) refer to „the way that social problems are created" and reality is already constructed before being interiorized, being a guide, which coordinates individual's life by making sense of it (Sandu, 2016).

• Psychosocial perspective, coming from Payne's work (as cited by Sandu & Unguru, 2017) which is focused on concepts like „identity, personality and perception in the psychological sense of social constructivism".

From this perspective the reality from the medical field can be seen as an "already constructed guide" which contributes to the way the students in nursing are building their professional identities. But this process of building professional identity is not starting from nothing, but is built on what we know as a personal identity which is was influenced by other „already constructed" guides from their personal lives.

Ohlen and Segesten (1998) consider professional identity from a personal and interpersonal perspective and their approach goes in the same direction. In their opinion professional identity is "integrated in the personal identity of the nurse". More, the identity of the nurse is linked, in their opinion, with "the way a person feels by being a nurse" which is a subjective aspect and "the image the others have about the person as a nurse" which is objective. The psychological factors are linked to self-esteem and sociological factors to the congruence between feelings and behaviors for the others, fulfilling the duties coming from the social role,

sharing experiences through narratives and reflection with other nurses. From their perspective ”professional identity is born in the process of socialization”, growing up along with the nurse during the interpersonal relationships and being sustained by self-reflection.

Considering the social constructionist paradigm on personality, Raskin (2002) cites Burr and Gergen's ideas, which are not recognizing a stable, fixed personality, seeing it rather like a social construct, built from the way that the others are talking about a person which also depends on the social contexts.

If we see the personal identity as a ”result of what the others are talking about a person” and if we think about the work relationships, what the others are talking about a person can be in relation to her professional behavior. In this context we can ask about how the first experiences might impact the start of building professional identity, considering the need for validation and consolidation that a beginner needs at the start of his carrier. The medical area is intricately linked to high moral standards (Nightingale, 1989) and that can make” what others are talking about someone” more important for the nursing students in their first experiences in the practical training. Burke and Reitzes (1991) say ”the identities get sense for a person (self-meaning) through social interaction” seeing identity ”like a compass helping us steer a course of interaction in a sea of social meaning” (Burke & Reitzes, 1991). And in this context the nurse identity makes sense in relation to the doctor's identity (White & Burke 1987). So, the other one's answer to the role identity is ”the base for developing the sense of self-meaning and self-defining” (Hogg et al., 1995).

4. Narrative approach

Narrative therapy developed through the contribution of Michael White and David Epston (1990; Besley, 2001), under the influence of postmodernist philosophy, is addressing the importance of the socio-cultural context in therapy and is considered the only therapy informed by philosophy (Besley, 2001) as a form of post-structural therapy. Gergen, Payne & White (as cited by Besley, 2001) positioned narrative approach ”within the social constructionist domain of social psychology

Somers (1994) talks about the reorientation of social theories from universality to concrete, towards what is recognized as an agency of a person as a determined factor of their own actions, a notion defined as a state of being in action or exercising power and linking to the concept of empowerment, one of the basic elements in narrative therapy. Some

clarifications are needed on how narrative therapy works, because the name may suggest a story therapy without being very clear to whom the story belongs to and what is its role in therapy. In order to better understand narrative therapy it is necessary to start from the influence of social constructionism, which goes beyond the boundaries of scientific study which began to imprint various professions (Javirnen & Miller, 2015) including Michael White's work who was influenced by Foucault's philosophy (White, 2007). Besley (2001) conducting an analysis of the evolution of narrative therapy emphasizes the importance of language and meaning in counseling, affirming the influence of language both on the framework in which we form our notion of self or identity, but also the meaning of life on which the counsellor and the client work together in therapy.

Besley (2001) talks about becoming the author of his own life (re-authoring life) by identifying identity stories alternative to the problematic story, in the narrative approach being linked to the process of building a new life story descriptively richer, practically a new reality. Through this process, connections are made within the multi-axis life story (for example from landscape of action to landscape of identity) from the action level to the identity level and vice versa, and by strengthening the relationship between those actions collected from the life story that are consistent with the person's dreams and desires and the identity derived from them. In this way that stories and actions related to them become preferred and the client acquires that agency to choose in the future actions that reinforce the identity associated with the preferred life story (Carey & Russell, 2003), which they call the preferred identity story. Basically, the narrative approach rejects notions of negative and positive in general, and speaking of identity instead of positive or negative identity issues, the concept of alternative identities (Freedman & Combs, 1996) is used, among which will be selected those identities that in the particular context of the personal life story will produce effects evaluated by the person as beneficial in the future. Carey and Russell (2003) explains the difference between "internal states of identity", which refers to stable internal traits specific to structuralism and the "intentional states of identity" with which the narrative approach operates and which relate to: intentions or purposes, values or beliefs, hopes and dreams, principles of life, commitments, which will guide possible future actions. Bruner (as cited by Freedman & Combs, 1996) sees therapy as "a process by which people experience choice instead of stable certainty about the realities they live". Talking about positive or negative identity characteristics comes from social discourses, or it may be the result of a

structuralist approach that divides actions or identities into positive or negative, based on widely established categories of social and keeps away the therapist and the person from the particular aspects that construct the reality of the latter. It is important to note that the idea of acting from the perspective of the preferred identity story will determine the conscious choice, following the therapeutic approach, of those actions that reinforce that identity and is in line with what Somers (1994) said about "acting in accordance with what they are", rather than in accordance with the values or norms promoted by the social category in which they were placed.

By ”people live their lives through stories and the way people are telling the stories are shaping their lives” (White, 2007) we understand that the way people tell their stories contributes to building a "reality" that becomes the "objective" world of the person, invested with sense and meaning. Born under the influence of social constructionism (Besley, 2001) narrative therapy approaches the story from the perspective of dominant discourses that end up "subjugating" the person (White, 2007) and shaping attitudes, actions, behaviors, but also creating ”unwanted identities”.

5. Narrative Medicine Program from the narrative approach perspective

The stories students in nursing encounter during the clinical practice involve pain and suffering and sometimes these are the stories which become overwhelming and as Charon (2016) was saying, no official record will allow the student to write about those touching stories. And in this context Charon (2016) signals the need for "rehumanization of medicine" and introduces the notion of "story" in medicine by developing the Narrative Medicine Program, designed to contribute to the development of listening skills and the use of storytelling in clinical practice and she created „parallel charts” for the residents so they can write about these touching stories somewhere. And this is the way that stories from the clinical practice came into the light in the medical field and it was inspirational for others and found it useful also for the students in nursing, because nobody tells them either how to deal with these stories from the clinical practice and how to make sense of them.

Narration is defined in Cambridge Dictionary (n.d.) as ”the act of telling a story” and the story is a description either true or imagined, of a connected series of events”, so telling a story might involve subjective aspects which are a part of the storyteller reality. In the same sense Todd and Fisher (1986) and Reissman (2005) consider stories as „bridges between

daily social actions and social structures on a bigger scale", meaning „the stories are describing the world as it is understood by the story-teller."

Starting from Charon's ideas of picking up the stories from the clinical practice, the Medicine Narrative Program held in Iaşi with the students in nursing from a post-secondary school uses the idea of bringing into group conversations the meaningful stories from the clinical practice of the students in nursing. The program of narrative medicine developed in Iași started with residents in obstetric and diabetology by a group of narrative practitioners and it was seen as an opportunity to give meaning to the experiences of practice, to understand how certain stories become significant, focusing on the development of the skills to manage the situations encountered in practice, using techniques borrowed from narrative therapy. In order to achieve this program, the outsider witness practice was used as a principle of addressing group meetings, in which there is a central storyteller, who will bring up his significant story, and the other participants will be in the position of outsider witnesses, in the sense of not interfering in the initial conversation, not critically assessing the actions of the storyteller or the people who appear in the story and reflecting on those heard through the eye of their own resonances, without issuing any theories. The best description of the outsider witness position is the unknowing position in relation to the experience exposed by the storyteller. Narrative therapy limits the role of an expert in a problem to its storyteller, because it considers its own life experience to be the best "trainer" for the person, in the sense of developing and testing in various other circumstances some life skills that make it competent, but which at some point are no longer visible. Positioning others as experts (including the therapist) to the person's situation and implicitly to the person would undermine the storyteller agency, creating an unequal relationship in which the construction of new meanings is no longer possible, since building a solid "platform" for the action to become possible for the person in difficulty is an important goal for narrative therapy. Moreover, this aspect was the most difficult to manage for the facilitator, as it was often found that the "expert's" point of view, the "knowing" position of the witnesses was often found, despite the initial agreement at the beginning of each meeting. By providing that "safe environment", in which the storyteller stays the expert in his life story, he manages to enrich his story, having the opportunity at the end of the witness' reflections to revisit the original story through the prism of what he heard from the others, producing what the narrative approach calls the enrichment for the storyteller but also for the participants (Morgan, 2000), often with the acquisition of new meanings for his own reactions,

strengthening values and attitudes congruent with his preferred personal and professional identities, in this case.

The name of narrative medicine makes it specific to medicine by bringing stories from clinical practice that can provide a deeper and more effective understanding of reactions to situations encountered by the students and can confer feelings of resonance, identification, retrieval of similar experiences with other colleagues, which can develop a more consistent sense of belonging to the medical environment. Therefore, the name of narrative medicine comes not from the medical effects of the program on participants but from the field from where the stories are coming, so the principle of working with significant stories can be applied in any field where the stories are considered to be important for the people involved.

What was also difficult in the program was the use of ”parallel charts” which has not been embraced by students participating in the program, probably because they are asked during the clinical practice to write "papers" and there are many documents they have to write (practice book, case studies) so they preferred to bring the story as they remembered it most of the time, responding to the requirement to write the story by saying that they know the story so well that they wouldn't need to write it down, which emphasizes that it's an impact story for them.

6. Results – conceptual categories identified from the central stories collected during the Narrative Medicine Program

The qualitative analysis of the data collected from the interview reveals a significant category that can describe the social framework of professional identity construction, based on the models and values to which future nurses have been exposed since childhood. In the transcribed interviews there are aspects related to the personal identity description that follows identity models from the family, from the church and professional identity description involving models both in the family and in clinical practice from the medical professionals encountered or even patients.

These personal descriptions come largely in relation to the stories from the clinical practice told by future nurses interviewed by the facilitator during the Narrative Medicine Program. The stories are connecting the medical experience with the personal life experiences considered significant for the given context by the students in nursing. Preferred identity refers to those identity descriptions that give the sense of agency, of being able, of being skilled and are associated with positive self-assessment, accompanied by increased self-esteem while those that lead to negative self-assessment

can cause feelings of distress (Hoelter, 1983; Hogg et al., 1995; Stryker & Serpe 1982; Thoits 1981). And yet, it was noted that the less preferred identity descriptions that were assessed as less desirable by their effects on the person or on their interpersonal relationships, have also an important role in building the story about the identity of the nurse. And these "not-preferred" stories proved to be important because the majority of those who brought them in discussion have "lived" them as moments of awareness for the need to change in order to be able to practice optimally as a nurse.

Therefore, we will have several subcategories in the Identity Description category, including the subcategory of preferred identities and the subcategory of less preferred identities. Preferred identities that describe the person in a socially desirable manner, may be considered preferred because of the perceived effects on the person or her interpersonal relationships. But also these descriptions align with personal values, with what the person knows about him/her or what is associated with the social role of a good nurse. The notion of preferred identity was used by Charmaz (2006) as a multilevel description, described hierarchically in relation to the state of illness which brings difficulties in achieving the patient's own aspirations and objectives. The narrative approach uses the term "preferred accounts of identity," which refers rather to the identities to which we tend to. If we think from the perspective of the narrative approach, which believes that "stories shape our lives through the effects they have on us by acting as realities" we understand that the way we perceive ourselves as persons can determine our actions. In this respect, subject to self-reflection, the personal characteristics of future nurses get dynamic, sometimes requiring moderation or polishing, especially when viewed from the perspective of professional identity, by the effects they may have on themselves or on interactions with patients or caregivers.

6.1. Preferred identities subcategory

The preferred identity subcategory was approached by participants from the perspective of reporting to itself, bringing to the fore features that they attribute to themselves by describing them as important for managing life situations that they have encountered or will encounter. And we are talking in this case about an intrapersonal dynamic of the characteristics described, but we have also an interpersonal dynamic of the characteristics understood in the interaction with others.

6.2. Preferred identities of the future nurse by reporting to itself

If we were to make an identity description of the profile for the future nurse as evidenced by the stories of future nurses interviewed, we would find aspects that come from the field of skills necessary to manage difficult situations, in which case we are talking about characteristics associated with courage, strength, power, necessary to overcome certain limits:

The need for consonance can lead to the reaffirmation of the characteristic of being strong in any circumstance, regardless of gravity, based on past experiences, which become a kind of landmark and logical premise: to have been strong up to a certain time automatically implies to be strong in the future. Viewed from a constructionist perspective, the student's action becomes an active process of past selection of premises that can allow him to build a preferred description of his ability to act: I was a person who could do things, so I am a person who will be able to do things.

> *"Simply, the power to deal with any situation. To face any problem, anytime. No matter what degree of severity it is. I said I had to resist, I had to do this, it is impossible not to be strong. If I've been strong before... If I've been before, why wouldn't I be on ward? "(I025)*

> *"Because there were moments in my life or at the hospital, they probably overwhelmed me, but I didn't get carried away, sort of..." (I025)*

> *"But! Um, I've had moments of balance in my life where I've been surprised by the way I've reacted. Positive. So, well, I've always found the resources to deal very well with even apparently crisis situations or unpleasant situations from…" (I01)*

If we look at the explanations of the students in nursing on their characteristics from a constructionist view we can say that the reality they are describing is a reality which tells about them a story of being able to deal with difficult situations, a preferred reality which makes the link between landscape of action and landscape of identity and we can understand this like a dynamic and multileveled construction of identity.

One of the personal traits which are underlined from the students' speeches is the strengths considered from two perspectives: a mobilizing one, which makes everything possible and one with negative valency, because it can take the shape of cruelty and that makes the need of limiting, of putting a boundary between to limit the negative effects. This limit can be done, according to the students with the help of their own feature. So, limiting a trait to stay in the positive area is the result of a construction effort

and it sustains the Berger and Luckman (2008; Sandu & Unguru, 2017) sociologic perspective on social construction of reality which being interiorized becomes a ”guide to coordinate individual’s life by making sense of it”(Sandu, 2016).

> *"well, pfff, nnn, I wouldn't want to say, maybe, in time, this strength doesn't turn into cruelty... Maybe it's out of place to... said. We have to set our limits probably, as always... (...) Everyone sets their limits according to... I don't know, his character, or.. how he feels.... I don't know. Well, so you have to be strong, really, because I'm..." (I01)*

Being strong is seen as an attribute of things that become possible for the respondent, as a factor of optimism versus weakness that is associated with "falling into the void", being also connected with aspects of moral capacities, those of remaining on the right path, which can be obtained by the call to divinity. Being explained as morally assigned, strength also invites to other behavioral characteristics, which achieve the plan of relationships with others, namely to be good and to help, in response to what can be called the meaning of life for the respondent.

> *"So I'm a pacifist, positive person and I'm trying to... I always thought, as we are laying in our beds, before falling asleep how we are, to think..."What am I for... Why I was born in this life?" ... Well, that's what I'm thinking, do we all have the good wolf, or what? The good side and the bad side. So let's get the good part out of us, because everyone has the negative side and the positive side. We have to get the positive side out of us and...". (I01)*

Also, the fact that "strength" is called Xena as a warrior model induces the idea that the development of this trait can give the student the ability to "do anything", but at the same time can induce the idea of work, of fighting to preserve this trait and not to fall into the extreme weakness occasioned by what the respondent calls many "negative things" that surround him in life, which can give meaning to the construction of the feature as a chosen, desired, preferred path.

> *"Like a Xena. Warrior and... I'm optimistic, I'm... I see like this: the light at the end of the tunnel, I see that I can do anything. When it gets worse. ... I'm falling like this... in a…in a void. Um, no, I just find the strength to…to move on, because... So, this Xena is making me move on. Because there are so many or, we go through problems every day, so many negative things surround us and we have to find... Always when I walk next to a church, maybe I can't always make a cross, but that's all I say, "Lord, help me walk the right path." Or "help my*

kids walk the right way." That's what this strength helps me: to find my right path, to be a good person and to help, to do as well as I can." (I01)

Professional identity, being a nurse, is explained by a nursing student as integrated into her own identity and as part of her life from now on, because the respondent can express herself very well through this profession and is the only one with whom she can associate for the rest of her life, giving to her professional identity the power of defining herself as a person. This description is sustaining what Ohlen and Segesten (1998) were describing as professional identity from a personal perspective being integrated in the personal identity of the nurse.

"I see it as a profession, I see it as... like something that's part of me and I'm really going to do it my whole life, I mean... " (…) I don't see myself doing anything but that. " (I025)

But not all the respondents identified themselves with the profession and there is more to investigate about what can make a student in nursing feel like being a nurse is defining himself.

Self-confidence is described by several students, being presented as a prerequisite for becoming able to face certain situations which makes them able to alleviate the patient's suffering. The need to trust oneself appears described by several students, being presented as a premise to become able to face certain situations which makes him able to reduce the patient's suffering, by being effective in what he is doing. Trusting what he will do, seen as a duty to the patient, affects the relational aspect between the future nurse and the patient, self-confidence being associated by the student with knowing what to do.

"I kind of feel responsible when I go before him to trust myself and what I'm going to do." (I025)

"To be... to have more confidence in myself (...) I'm going to trust myself to do everything I can to... so that people don't suffer anymore?... (I030)

Memo: *Some of the respondents' statements are answers to the facilitator's questions about what self-confidence means being linked to becoming better, more empathetic. Basically self-confidence becomes a developed attribute to access or improve other socially desirable or preferred identity descriptions.*

6.3. Preferred identities of the future nurse described in relation to the others

Strength from a professional perspective is described by reference to a type of preferred interaction, that of becoming able to help, to be able to manage relationships with patients or caregivers in the sense of being able to detach yourself emotionally and to "do your job". The strength is linked with the need to have self-control and in opposition to weakness, which can lead to the appearance of blockages in reaction what could cause more suffering to the patient. Strength appears to be necessary once the students is entering into the clinical practice and requires a development effort sustained by experience, by acquiring the knowledge and skills necessary to be able to intervene effectively from a medical point of view and to increase the ability to manage emotions.

Memo: *From the students' accounts, situations where the patient may suffer more either through the situational context (a situation where the patient is at the boundary between life and death) or through more invasive medical maneuvers, are considered by respondents to be situations in certain wards where more strength is needed. As being directly exposed to the patient's suffering and focusing on his suffering the student may fail to perform the medical intervention that might help the patient. Moreover, the student can also become a victim, which would make the medical team's work more difficult and implicitly harm the patient.*

> *"These are important, but sometimes I should also strengthen because I as a patient if a situation shows up... I, as an assistant, if there's an emergency, I'm not going to let me get sick when I have to take care of that emergency. That's why I didn't even know how to get out of the room faster so I didn't... so I won't become an emergency there myself." (I030)*

> *"To be able to help that person. Because if I'm in control of myself and I trust myself to be able to help him, it's like I'm not getting stuck like this anymore and I'm more easily over the situation and...". (I030)*

> *"And now... I see this strength from a legal point of view... So from this medical side. So you have to know how to keep the relatives at distance... somehow, so you can do your job, to let you do your job, because they overwhelm you, they want to see, they want to know everything..." (I01)*

> *"That's basically... you're probably acquiring it with experience... because...". (I01)*

From being good to being ordered is an association made by a respondent between the quality of healthcare and good organization,

explaining the term good nurse by being ordered, organized, describing the hospital environment as chaotic, laden with bureaucracy and movement of "papers", which are in fact medical documents surprising as representative aspect of the bureaucracy part of the field.

Memo: *The respondent had been employed in the hospital for a long time in different positions and the main problem raised was the crowding of hospitals, the constant movement of patients, who are accompanied anywhere by medical documents. In fact, his answer went from the effects of being a good person and went from question to question to being able not to rush. Not rushing implies the idea that crowding in hospitals makes everything unfold quickly, without patience for patients, the movement of "papers" taking precedence over patients' problems.*

Being able to listen to people is an identity description that is seen as desirable and that brings countless personal satisfactions, being associated with the love for people: if you love people you love them and their stories. Listening is associated with kindness, because the respondent introduces the idea of his own effort to listen but also to learn from patients' stories, learning to be better being affirmed as the main reason why the respondent goes to practice.

> *"But I'm the kind of person who listens to you as much as you want to tell me." (I09)*

> *"The fact that I love people and I love their stories. (…)And I love listening to people, whether I have time or not, I can spend five or ten minutes talking to someone." (I025)*

Moreover, the desire to connect with people is further explained by character, but also by the support of others in the desire to help, which underlines on the one hand the role of the personal effort to be good but also of significant people in the manifestation of certain attitudes or actions consistent with their own self-image, including patients in the ward who witness a certain kind of being.

> *"It connects first with me because I have to be good to myself. I'm going there to learn for myself. Second, of course, are the patients of the... the others who are by my side in the hospital room. (...) I don't back down and every time I help and.... (...) The character and the support of the loved ones. (I025)*

Having the necessary knowledge as a nurse is a description in the sphere of professional competences arises by reference to the scope of the doctor's competences. As a necessity underlined by the participation in limit situations that students were able to attend, which led them to realize that although the doctor is a decision-maker, he cannot be present all the time

and it is very important that they have the necessary knowledge to intervene or anticipate the doctor's intervention when appropriate. Also helping becomes more effective when nurses' help is informed by knowledge, when she has the necessary knowledge to make the right decision. But what the respondent considers important is to understand that the knowledge and to know what to do in order to help the patient it is necessary to overcome emotional barriers, fear, to be in control of the situation being presented as a necessary condition for a coherent and conscious intervention.

> *"Well, that doesn't have to be seen, you have to overcome that fear, you have to be in control, first of all on technique, on theory, to know what to do." (I01)*

> *"The fact that I have the necessary knowledge that can help me help that person. (...) That's why I'm thinking now I see that more and more to... I formulate ideas. I don't know... Well, I don't know, if I trust myself and I'm in control of myself I know exactly how to act according to the knowledge I have to know exactly how to act when a man suffers. And to say that I can no longer give up…" (I030)*

Memo: *The awareness of the moment when the student realizes the importance of having the necessary knowledge is called a moment of crisis, when she basically understood that not understanding what is going on, not mastering the knowledge can be fatal to the patient.*

> *"I've learned, I know, I've seen how it's done, I know how to do it, there's nothing to do, I have nothing to fear. " (I01)*

> *"No, no, no, no, no, that was the crisis itself. Then the rescue arrived. The ambulance was called to take him to oncology directly. But this was the crisis. The crisis is when you actually realize that you need to learn a lot more, gather a lot more information and ask a lot more questions in case something happens." (I047)*

The idea that "you need to know very well what you're getting yourself into" refers to the awareness of the responsibility to perform healthcare-associated maneuvers, with one of the respondents citing consciousness as motivation not to harm, bringing into question the idea that a nurse can "have person's life in her hands" and this is about learning responsibility from the more experienced nurses.

> *"I just don't want to make a mistake because in my hands is a person's life. And much more important is to do something right than to have something happening and to have it on your conscience that something much worse has happened because of you. For example, nurse said about the subcutaneous injections, the*

ones that are done periombilical, in very weak people, you can prick an intestine and then you can...(…). Then he goes into surgery, which means there was already a whole story in my head, a different story. And of course you have certain fears of doing good, of not hurting someone intentionally...or because your lack of knowledge or ignorance, or, whatever. I mean, you have to know exactly what you're getting yourself into. Well, don't do harm. " (I01)

Patient's well-being as a reward for future nurse arise in the student's speeches. If doing good is for some students the result of being strong, other participant's responses surprised a particular aspect of "doing good" that is linked to the way of relating with the other. The well-being has been described as the result of a certain type of interpersonal interaction that targets the interlocutor's smile as evidence for student's contribution to the well-being of the other. The student sees in his contribution to the well-being of the patient a kind of medicine for his own state of discomfort generated by various other reasons and listening to the patient's stories adds to what the future nurse calls "kindness" and his state of "happiness", explained by "nourishment" for himself.

"I mean, that warms me up: when I know that a person is smiling and you're keeping them... Happy! ... if he's feeling better. That's what I'm happy about – (...) I can say it's like some kind of medicine, though it would sound weird again. Even though I feel bad, when I see people like... (short break) that they feel good around me, I don't know... I feel better. Even though I'm hungry, even if I'm tired... I don't know, I... it's like I'm still getting over it..." (I014)

"It gives me more kindness. More happiness, it makes me happy at the moment, and I keep all the stories and all the... " (I025)

Memo: *Engaging in behaviors that bring satisfaction from the first interactions with the patient could lead to their preservation as a preferred mode of interaction, strengthening the preferred identity aspects, such as the listener or person who cares about the patient, as in the case of previous examples. The technical skills at the beginning of the practice being still in development could be offset by the need to strengthen the moral skills often associated with the nursing profession.*

The desire to be helpful to others is also a preferred identity description, being considered a trait learnt in the family, from parents and grandparents since childhood, the grandmother being identified as a representative image for "helping".

"It gives me the power to help, plain and simple. (...) To be able to help, for me I think it's a first feature so to speak. I've been trying to help since I was a kid. And I was taught to do that... (...) By the parents, by the grandparents,

especially. Because my grandparents and I spent most of my childhood together. Even when I was small. (...) Grandma" (I025)

In the category of desirable traits is also the desire to connect with people, described as a personal characteristic learned by one of the respondents and transferred to the professional field, thus preserving the consistency of personal identity, being validated through recognition by experienced nurses who are appreciating the student's contribution to their work and recognizing the aid received as unique:

"I think I meet these experiences every day because I'm not.... (...) When I first went into the hospital and I was…received with great fondness by the other nurses and the fact that it is still the same. Every time I leave "I025, thank you, I hope you come again. I think you're the only one who can handle what we do and to help us and..." simply that thank you thing that I did something today and didn't do it for nothing" (I025)

If we see the identity like Raskin (2002) was describing it, built "from the way the others are talking about a person" an interesting aspect in the description of both personal and clinical practice interactions is that of the way that students are reporting to the opinions, assessments of others, which are considered by the majority of respondents to be secondary to the their self-assessments and not so important.

But if we consider the approach of errors in accomplishing the first medical maneuvers or the assessments from the medical stuff or the patients, despite the general statements concerning the opinions of others, students in nursing, not only describe them as important, but moreover they act to limit errors as much as possible and to multiply actions that give them recognition from the patients:

General appreciations about the students in nursing which are not related to the medical field are in line with a social discourse that argues that says "the mouth of the world does not matter", but is more important "cleanness of consciousness", even at the cost of important personal discomfort for some students, perhaps with the intention of ignoring those opinions that would diminish the agreed self-image.

"Well, no... to me doesn't necessarily meters... The image. I'm the kind of person who didn't take into account what people say, I mean I did what I wanted, no matter what they are saying...that people see you, what does people say? I'm not interested. As long as I have a clean soul and I'm doing good and I think I don't want to, I don't suffer, I don't care and it doesn't actually affect me..." (I01)

„Because it's me. Relationship with myself is more important than relationship with others around me. Because at the end of the day, the night I go to bed, it's me and myself. (…)Of importance, yes. It's more important to be peaceful with myself no matter how many panic attacks and how much anxiety this whole thing gives me. I know that in the end I can be at peace with myself. "(I050)

The particular situations about the actions of the future nurses, seems to matter and to be reflected in their personal and professional identity and directs the student to collect stories from the preferred reality side of the practice, selecting those stories that make desirable identity descriptions with effects on the possibility of action for building and preserving those characteristics that are perceived by them as useful and appreciated by the evaluators, perhaps out of the need to preserve and convey an agreed, comfortable self-image.

Acceptance of assessments from others – comes as a validation of the preferred identity, either personally or professionally, with reference to the student's contribution to improving the patient's condition or to the medical maneuvers performed. Validation is provided not only in verbal form by effective communication of the assessments by the patient but also by "reading" in the eyes of the patient's gratitude. Some assessments on the part of patients are very touching for students because they are put directly in touch with their behavior towards the patient and are aware of how they are seen as people and future nurses by the patients, which may motivate them to want to preserve that identity description that brings them satisfaction.

"The fact that people when they leave or say goodbye and I'm there just leave me a smile, or say to me that "you made me happy while I was here and you made me better and for that I thank you"" (I025)

"Oh, no, but she had, that twinkle in her eye for the fact that I cared for her and she said that... He told me the name X isn't... it's not by chance and that I'm made to make people better and... " (I025)

Patient feedback addressed to both the relational part and especially the medical maneuvers performed for the first time take significant dimensions in the sphere of the professional identity of some learners, especially when they receive assessments of medical maneuvers performed with minimum suffering. The student receives the patient's response to the first injection with wonder, but at the same time realizing that "having that easy hand" is an asset in healthcare, often being associated with a talent, with a native endowment more than a skill to practice.

"yes, I have tears of emotion, of happiness, of the fact that, I've never heard…So she was the first patient to tell me these things and it was like this... I said..."myself? You mean me? Are you even talking to me? Are you really telling me this?" Yes. It was... it was emotional. Very emotional." (I025)

"Last days I made an intramuscular injection, my first one, by the way, even if I am in the second year of studies, only now I managed to do this kind of injection. And the patient, it was a male, said he didn't feel anything, and that I have a good hand (easy hand, in Romanian, which means it doesn't hurt). And after some days I tested him for an antibiotic, I mean, I made him an intradermic injection with Ceftamil, to see if he is allergic at Ceftamil. And, the same, when I went to give him this injection the initial plan was that another colleague of mine should've give him that injection. But when the patient saw her he asked for me. And I was surprised and looking at him because I didn't understand exactly what he meant, I was not paying attention to him. And then I realized that he was asking me to give him the injection and I was like…I was so surprised. I didn't expect to have such a good hand in making injection." (I014)

The timing of the first injection was described by the perspective of the patient's concern, the claim that after the injection the patient was fine, may suggest the student's concern at the first injection to the possibility that the patient may suffer, and the fact that he was also requested for the next medical maneuver allowed the student to understand the authenticity of the feedback received. Although he explains at one point that he is also preferred by the patient to do the injection because of his willingness to listen to the patient, to see it as a whole, concerned about the psychological side not only the singular execution of the medical maneuver.

Memo: *In the technique of drug administration, as in any medical technique learned at school, the mental and physical preparation of the patient for the technique is taken into account, and the description of the student matches the "by the book" realization of the first injection, thus obtaining confirmation of both theoretical training and practical skills not only of execution of the technique but also of communication with the patient.*

"I mean, I have a few more things to add. When I did that intradermal injection and the patient refused my colleague, I had a kind of mean, kind of joy when he told me that I had a light hand. At first I was happy that... Wow! I'm fine, it's okay, the patient's fine. I can handle this! (…) Hmmm, I felt the need to tell someone that... I felt good at the time, that I did everything ok, the injections were done well and the patient was satisfied, but not really, I didn't really have anyone. I mean, if I told anyone it was that kind of... Okay. (…) I don't know, I felt good, I had a moment of joy. And these moments don't... I don't have them that

often. I mean, it's not something you do every day, at least, not right now. (…) I did it, because I did it right. That the patient didn't say... or he didn't turn me down the next time I went to him.... (…) It's probably also because I... not because of... probably also as a result of talking to him and my colleague before, I've made jokes, I've... I mean, I tried to de-stress them a little bit, not to stay so serious, to avoid not talking to them, not paying attention to them, or not listening to them. " (I014)

Having a soul is one of the few identity descriptions that are described by a close person and which refers to the emotional part of the student presented as part of the preferred identity, otherwise emotions are generally judged by the prism of lack of strength, which could undermine the activity of the nurse in terms of both personal lucidity and interaction with patients or caregivers.

Other important aspect is the concern about making mistakes seen by the patient or experienced nurse which is a voice heard by the student in nursing.

Although as a general description "mouth of the world" does not seem to matter to some respondents, in terms of mistakes, their descriptions show particular concern to make a good picture, to show that they know, their motivation being mainly related to the fact that it is a new field, and the impression that others make of them acquires other valences, precisely in the light of the fact that they could be evaluated as inept or incapable and these descriptions overshadow their preferred identity as a nurse, for which they do not yet appear to have sufficiently solid benchmarks. If in the personal life self-knowledge allows them to be deaf at the mouth of the world, on the professional side, the status of novice makes them receptive and attentive, and this state of "alert" to mistakes seems to influence their actions and make them hide the emotion of the first attempts, even if natural, in their perception associating with insecurity, ignorance.

"Like anything, like any beginning, for example, for me it's a new field. I come from whole other areas. I practiced medicine at home with my kids and my family, so I didn't have to deal with the injections, the... to if, to... So. Um, everything is new and is normal that I still have certain moments where I say maybe it's not good, maybe I'm still insecure, so I have moments of uncertainty and then no!" (I01)

Memo: *Changing the infusion, depending on the size of the vein or the positioning of the venous cannula can lead to situations mentioned by students as very stressful, but when medical skills are in training they acquire significant proportions for the*

student being linked in their perception of clumsiness, lack of medical knowledge or skills etc., and they can gain weight if coming from experienced nurses or from patients.

> *"Or there were times in the first stage when, well, you had to change an infusion you had to keep.... to do stasis, I probably didn't know where... Well, You had to put your fingers in a specific place and the blood was coming and... Yey !! Shock and panic! Put it up fast, what are you doing? Wipe the blood, the nurse comes, sees me... the patient sees blood, wow!" (I01)*

There is a need to make a good impression on the experienced nurse, to be seen as a "knower" in matters of medical maneuvers, which actually underlines the need to validate an important component of professional identity: that of knowing. The students are very impressed about the feedback from their patients and they are very preoccupated to not make mistakes, because, the mistakes would say a story about them, a story they do not like and it could link to a sense of identity they are not enjoying. It seems like they need good stories and they pick them up from the clinical practice.

Not being in control of yourself as a future nurse in clinical practice in interaction with the patient can lead to invalidation both from the perspective of the patient who, in the student's perception, would lose confidence, but also from the perspective of the nurse, who could judge the competence of the future nurse on the basis of a few drops of blood that would flow when the infusion changes, which causes the student to be very vigilant and perfectionist in carrying out medical maneuvers, especially when he knows that he can be seen by the patient on whom he performs the technique, by the other patients in the ward or by the experienced nurse.

> *"You're losing your confidence. It's not about judging... The treatment that others might have with you, it's about... I don't know, the fact that you won't be seen the same. As a person, I don't know, capable or competent. Well, these things are also from the perspective of a person with a... not a handicap, with a deficiency. Will always pay attention to these things. " (…) It's not that I don't accept, it's that it would eventually affect me. Because it affects us all. No matter. The moment you're being judged for a mistake, you're... You're losing... "(I050)*

> *"Sometimes when I was taking medication or, for example, if I had 2, 3 syringes in one patient and I had to stay a lot, sometimes my hand would shake and I would say in my mind "I025, not now. Now you have to do good. Now you have to be confident in yourself and to resist" (I025)*

Some students try a reasoning to normalize the mistakes of a beginner, but retain the idea of labeling, invalidation that can come with the

mistake made and seen by someone more experienced, although the first criticism comes practically from self-assessment, because they consider as mistake certain incidents quite common in medical practice and anticipate a negative feedback.

> *"And I consider that to be wrong is human. I believe that in absolutely every area there is a mistake. We cannot be perfect. That is clear. And I think we need to learn from mistakes. But the fact that I could be judged, and I could be blamed for that mistake to be for example intentional, already would be a problem and sometimes you are judged on mistakes based on... reactions." (I050)*

> *"At the end of the day, there are human mistakes, but if people see this thing, they take it as: "Oh, but she has no experience, she doesn't belong here."." (I025)*

Aspects of personal identity to develop or what we can call **intentional preferred identity** it is a subcategory that does not necessarily mean that this part of the life story needs to be neutralized, hidden, but identified and "worked-out" or developed to get where becomes "helpful" to the student in nursing.

The need to develop some parts of identity perceived as undermining the nursing profession in the descriptions of students refer to some aspects of personal identity to improve related to the emotional development perceived by students as important for the effective management, difficult or problematic situations. As undermining factors are presented pessimism, weakness and as aspects to develop would be self-confidence that can provide more power to help and the need to develop the ability to access one's own resources.

> *"I think... It's a thing that gives me hope that... or a note of optimism. I consider myself a pessimistic person, but the fact that I also sometimes find the courage to get over certain problems.... I'm saying I'm starting to get optimistic (laughs), or I don't know. In that sense... to move on. " (I01)*

> *"I mean, I need certain resources to become like... "(n.a. a nurse) (I019)*

> *"And I think you took things so gradually, gradually and how to say... This gradual desensitization I think would help me. I don't think so. I'm sure it will." (I019)*

> *"That I'm going to get better at what I'm doing, that I'm probably going to have more confidence in myself, that I'm going to have more power to deal with situations, I'm going to have more medical tactics to do interventions or (...) Or help others. " (I025)*

Introversion is an identity description explained by the respondent by making it difficult to communicate with people in general and with children in particular, being seen as a minus in the nursing profession, which determines the need for action in improving this aspect.

> *"And... I had a... I have some, I don't know…restraint to... be around children, talk to them. Good. And with people, it's hard sometimes to communicate. That I have so... Aaa, because I'm a little inverted. Okay, a little more. (...) I'm a little more... I mean, maybe I'm retired at the same time, and I'm trying to do things to be okay, to... " I014*

To be perceived as a conflicted person – comes from the student's perception as a result of the identity of a defender of dignity, dignity being in her vision incompatible with compromise in certain situations, which may make you not seem a very malleable person in relations with others.

Memo: *although dignity has been identified as a very important value for the student and is recognized as a moral value to which she adheres, the student considers it a positive characteristic only in relation to herself, in interpersonal relationships having rather harmful effects, therefore being worthy is described by the student as a trait to which there is still to the need to work.*

> *"And in relation to others because it doesn't make you an extremely malleable person. At least it doesn't make me an extremely malleable person, in the sense that I won't readily accept certain things." (I050)*

Medical stuff counterexamples influence embracing the preferred identity, or examples of behaviors or attitudes understood by students as not suitable by the effects they have on the interaction with patients in particular, play an important role in shaping professional identity in future nurses interviewed.

In valuing equality, seen by the student as natural, as coming by itself, he could not identify a clear model from which he learned this value, but experiences seem to be more connected to the hospital, either by examples to follow or by counterexamples.

Students explain the behavior of hospital nurse who do not live up to their expectations through stress and nerves accumulated in the work force, considering somehow explicable that after 30 years of experience you lose your empathy, but some of them affirm the desire to stick to the way they were "built" to behave considering that the attitude towards the patient should be dictated by the awareness that instead of the patient can always be a close relative.

Memo: *The theme of empathy conveyed by "put yourself in the patient's place" or "think that on the hospital bed or on the operating table could be your mother, your brother, your grandmother" is common in the speeches of teachers who teach future nurses, which is worth investigating separately.*

One of the respondents describes a situation in which he assesses a nurse's attitude towards himself through lack of empathy and explains it by the effect of the system on the person, stating that it would not be a singular attitude and that experience in the medical field leads to the loss of patience, compassion and humanity, which suggests that the hospital environment, the system in which you integrate as a future nurse changes you, without explaining specifically what might motivate the change, but sneaks a note of personal description that goes to explain the change by lack of vocation in the choice of profession. In other words, a person without a vocation is changed by the experience of the system:

> *"That's what I've never said before. But it was obvious. (…) I put it on the base, I don't know, that you work in the system for 30 years and somehow become immune as a consequence of working in the system. And the fact that at some point you become somehow, you lose your empathy, your patience, your compassion, your... of these things. I think that's what I've seen: a lot of people who have been working in the system for a long time. They are losing these things. The human side of the job is losing." (I050)*

7. Discussions and conclusions

The results of the study are underlying the importance of the **preferred identities in nursing** which are described by the students in nursing participating to the Narrative Medicine Program from many levels: reported to themselves, reported to the others. There are also many aspects described like models from the prior experience to nursing, like family, friends models from the clinical practice which shaped their perception about the way they should or could be and also there are some aspects which are not preferred and which we can call **intentional preferred identity.** Intentional preferred identity can refer to the way that a person prefers to be, meaning a process of developing or to diminish a state of identity in order to get it or to overcome it. So, what is not preferred it is not described as unwanted but as something to work on or to develop further for being a better nurse.

Other important descriptions are the ones from the first medical maneuvers of the students and if we stick to the White's idea that "stories shape peoples' lives" (2007) the story of the first medical steps made by the

student in nursing can become a part of his preferred reality if his performance was good enough or a part of the problematic reality if not. If stories shape people's lives, professional life is also shaped by the stories from the learning environment, including the clinical practice. And what is important from the students' descriptions is that these stories are coming from interaction with the others and with the self, in the sense of the meaning they are giving to the stories they are constructing about themselves. If we look at the professional stories of the students in nursing from the narrative approach perspective we can see the developing of the professional identity of the future nurses in a multilevel and dynamic process moving within the intrapersonal level and also within the interpersonal level through stories and influenced by the social context. Seen like this, stories from the clinical practice can be recognised as being a part of the professional identity developing in future nurses and that can lead to the need of making more place in the curricula for the stories the students in nursing are encountering in the clinical practice in order to help them managing the touching stories by making sense of the stories' significance to them.

This article focused on the concept of preferred identity in professional identity development in future nurses, but there are also important aspects like the relational perspective of the professional identity which are also very important, because we can ask how a person choose that preferred identity? How the other influence our way of choosing the stories? How is community influencing the way we choose?

Wenger (as cited by Barrow, Mckimm, and Gasquoine, 2010) was saying, concerning the professional identity of the future doctors and future nurses, that they "are a part of some significant relationships in the institution where they perform their clinical practice" in what they called "a constant work of negotiating the self" Barrow, Mckimm, and Gasquoine (2010). In what way selecting our preferred identities can influence this negotiation of the self in interactions with the others?

References

Barrow, M. J., Mckimm, J., & Gasquoine, S. (2010). *The policy and the practice: early-career doctors and nurses as leaders and followers in the delivery of health care.* Advances in Health Sciences Education. DOI: 10.1007/s10459-010-9239-2

Berger, P. L., & Luckmann, T. (2008). *Constructia socială a realității*. ART.

Besley, T. (2001). Foucauldian Influences in Narrative Therapy: An Approach for Schools. *Journal of Educaltional Enquiry, 2*(2), 72-93

Burke, P., & Reitzes, D. (1981). The Link Between Identity and Role Performance. *Social Psychology Quarterly, 44*(2), 83-92.

Cambridge Dictionary. (n.d.). https://dictionary.cambridge.org/dictionary/english/story

Carey, M., & Russell, S. (2003). Re-Authoring: Some Answres to Commonly Asked Questions. *The International Jurnal of Narrative Therapy and Comunity Work, 3*. https://pdfs.semanticscholar.org/1daa/1a25d18b538cd2e3e60f4776ec77648e06aa.pdf

Charmaz, K. (2006). *Constructing Grounded Theory. A practical Guide Through Qualitative Analysis*. Sage Publications Ltd.

Charon, R. (2016). *Narrative medicine: honnoring the stories of ilness*. Oxford University Press.

Freedman, J., & Combs, G (1996). Narrative Therapy. The Social Construction of Preferred reality. https://www.researchgate.net/publication/232464179_Narrative_Therapy_The_Social_Construction_of_Preferred_Realities

Hoelter, J. W. (1983). The Effects of Role Evaluation and Commitment on Identity Salience. *Social Psychology Quarterly, 46*(2), 140. doi:10.2307/3033850

Hogg, A. M., Terry, J. D, & White, K. M. (1995). A Tale of Two Theories: A Critical Comparison of Identy Theory with Social Identity Theory. *Social Psychology Quarterly, 58*(4), 255-269.

Javirnen, M., & Miller, G. (2015). Social Constructionism Turned into Human Service Work. *Qualitative Sociology Review, 11*(2), 198-214.

Morgan, A. (2000). *What is narrtive therapy? An easy-to-read introduction*. Dulwich Center Publications.

Moriss, S. B., Chrysochou, P., Christensen, J. D., Orquin, L. J., Barraza, J., Zak, J. P., & Mitkidis, P. (2019). Stories vs. Emotions and action taking on climate change. *Climatic Change, 154*, 19-36, https://link.springer.com/article/10.1007%2Fs10584-019-02425-6

Nightingale, F. (1989). *Notes on nursing: What is and what it is not*. D. Appelton & Company

Ohlen, J., & Segesten, K. (1998). The professional identity of the nurse: concept analysis and development. *Journal of Advanced Nursing*, *28*(4), 720-727.

Raskin, J. D. (2002). Constructivism in Psychology: Personal construct psychology, radical constructivism, and social constructionsim, *American Comunication Journal, 5*(3), 1-26.

Reissman, C. K. (2005). *Narrative Analysis. Narrative, Memory & Everyday Life*. University o Huddersfield.

Sandu, A. (2016). *Social Construction of reality as communicative action*. Cambridge Scholars Publishing.

Sandu, A. (2018). *Workshop. Teoria fundamentată pe date (Grounded Theory). Construcția categoriilor.* Lumen.

Sandu, A., & Unguru, E. (2017). Several conceptual clarification on the distinction between constructivism and social constructivism. *Postmodern Openings*, *8*(2), 51-61. doi: http://dx.doi.org/10.18662/po/2017.0802.04.

Somers, M. (1994). The narrative constitution of identity: a relational and network approapch. *Theory and Society, 23*, 605-649, doi: DOI: 10.1007/BF00992905

Stryker, S., & Serpe, R. T. (1982). Commitment, Identity Salience, and Role Behavior: Theory and Research Example. *Personality, Roles, and Social Behavior*, 199–218. doi:10.1007/978-1-4613-9469-3_7

Thoits, P. A. (1991). On Merging Identity Theory and Stress Research. *Social Psychology Quarterly, 54*(2), 101. doi:10.2307/2786929

Todd, A. D., & Fisher, S. (1986). *Discourse and Institutional Authority: Medicine, Education, and Law*. Ablex Publishing.

White, C., & Burke, P. (1987). Ethnic Role Identity Among Black and White College Students. An Interactionist Approach. *Sociological perspectives, 30*(3), 210-331.

White, M. (2007). *Maps of narrative practice*. Norton.

White, M., & Epston, D. (1990). *Narrative Means to Therapeutic Ends*.Norton.

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