Cultivating Professional Meaning and Commitment: Frontline Nurses' Narratives about Peer Support

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Abstract

This dissertation explores frontline nurses' perceptions of peer support in fostering emotional, professional, and organizational support and commitment in different contexts. This study draws together scholarship on street-level bureaucrats (SLBs) and formal and informal training in nursing to build on research demonstrating that internal organizational elements such as formal training and informal peer interaction continuously develop SLBs' professional and organizational personalities. Also, research traditions on SLBs regard peer interaction as policy implementation using "service styles" to build stronger ties with peers to solve problems and better respond to the needs of citizens and communities. Despite the prominent role peers play in scholarly research on SLBs, few empirical studies have contextualized the meaning of peer support in different settings to examine how it affects professional meaning and organizational commitment in a specific industry. This dissertation expands on the findings of several studies that demonstrate that peer relatedness is an important component of frontline work. The distinctive contribution of this dissertation is using narrative analysis to collect and analyze stories of firsthand experiences told by personal narratives from mental health, military, and emergency nurses in public hospitals to thoroughly compare the perception of informal or formal peer support influence and highlight its evaluative aspects across different settings. This dissertation contributes to the street-level bureaucracy theory by providing empirical evidence in contextualizing peer support as a catalyst for emotional support and a buffer for organizational uncertainty in various emotionally charged healthcare settings.

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General Audience Abstract

This dissertation focuses on the narratives of frontline nurses in mental health, military, and emergency settings to highlight the impact of peer support on nurses' emotional well-being, as well as professional development, fulfillment, and commitment in diverse healthcare environments. This study illuminates how formal (preceptorship) and informal (mentorship) training or peer support shape nurses' professional identities, engagement, and commitment. Despite the acknowledged importance of peer support in public administration scholarly discourse, few studies have explored its nuanced significance across different healthcare settings. This dissertation addresses this gap by employing narrative analysis to examine narratives from mental health, military, and emergency nurses in public hospitals. By comparing informal and formal peer support perceptions of these different types of nurses, this study explores the realities of frontline healthcare delivery, including the emotional toll and systemic challenges they face, personal development lessons learned, and dynamics surrounding co-supporting quality care through peer support. Subsequently, this study highlights the critical role of peer support in developing and enhancing the psychological drivers — autonomy, mastery, purposefulness — and social drivers — supportive workplace, sense of belonging, and psychological safety— of nurses, thereby fostering a supportive environment and enhancing their competency and the quality and safety of patient care.

DEDICATION

This dissertation is dedicated to my mother, Awa Diarra — may peace be upon you.

She has always viewed me as intelligent and empowered me to be who I am today.

She consistently understood me and was there for me whenever I needed her,

My best friend she was,

Her confidant I was,

I wish I could tell you how much I miss you,

I wish I could show you the person you shaped me to be today,

I wish that my future wife and children could meet you,

I want to thank you for never doubting me, and this dissertation is a tribute to you.

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CHAPTER ONE: INTRODUCTION

Background of the Study

At the beginning of my doctoral journey at Virginia Tech, I took several foundational courses to enhance my understanding of public policy. One course in particular, "Public Policy Design and Evaluation," left an indelible influence on my life. As a nervous first-year PhD student, I wondered how challenging and eye-opening this class would be. I realized that my nervousness did not outweigh my excitement when the professor, on the first day, introduced a policy analysis class that shifted from policy disciplinary influences such as economics and business analytics to narrative inquiry. What I did not realize at that time was that, at the end of my journey, I would be collaborating with my professors and colleagues, Dr. Dull, Dr. Bredenkamp, David, and Professor Leisha LaRiviere, on a research paper titled "Frontline Service Narratives and Workplace Identities in Behavioral Health and Developmental Services."

Furthermore, my dissertation is a result of a shared reflective dialogue between this class and the research project. This project explores how frontline professionals construct occupational and workplace identities by analyzing stories from frontline service professionals across three occupational categories—psychologists, nurses, and direct service professionals—working in behavioral, developmental, and forensic service capacities within the Virginia Department of Behavioral Health and Developmental Services network of organizations. The research team employs an iterative qualitative coding and interpretation process to examine frontline-ness as a variable defining differences in worker stories across practice contexts. This project analysis draws from self-determination theory to reflect on how environmental conditions — relatedness, competence, and autonomy — manifest in stories of motivation and the internalization of value

commitments and to enrich and contextualize scholarly thinking about workplace motivation and considers aspects of the roles and contexts that are observable (seen), intrinsic (unseen), and associative (membership-derived).

I, on the other hand, was curious about how peer support is perceived in the nursing community and how peer support as a preceptorship or mentorship affects the larger lives of mental health nurses, military nurses, and emergency nurses—their professional and personal identities, professional actions, peer relationships, and commitment to the profession, peers, or organizations? My dissertation then intends to delve deeply into the stories of these three types of nurses to qualitatively explore how peer support—preceptorship, mentorship—manifests in stories of their day-to-day professional lives, professional meaning, and organizational and professional commitments, as well as contextualize scholarly thinking about the meaning of peer support in various nursing settings.

Problem Statement

Lipsky's (1980) work serves as a model for suggesting the crucial role of street-level bureaucrats (SLBs) in policymaking, inspiring social interactions and professional discretion to be central to government policy implementation. SLBs' research has shown that implementing government policies is a supportive learning process based on daily judgments and peer relationships. For example, Brehm and Gates (1999) show that "solidary preferences," or developing friendships with coworkers, are among the best predictors of SLBs' behavior. Nisar and Maroulis (2017) point out that peer interactions assist SLBs or frontline workers in making sense of their work, facilitating their work process, and providing social support. Siciliano (2017) also highlights that SLBs rely on their peers' social interaction, supportive environment, and

advice to learn, improve their performance, and drive policy results. This tradition of scholarship on networks and relationships points to greater opportunities to contribute to SLB research. For example, despite increasing scholarship on networks and relationships, there has been less research on peer support characteristics that can influence the development of professional meaning and organizational commitment during the implementation process (Lotta & Marques, 2020; Maroulis, 2017; Rhodes, 2007). Understanding peer support components is critical because government service delivery heavily depends on SLBs' experience and support. For example, SLB's action decisions are not independent answers to citizen clients' challenges "but rather are developed and shaped by specific features of the social structure in which the individual bureaucrat is embedded" (Siciliano, 2017, p. 79). That is, through peer informal interactions and support, SLBs learn and develop necessary bottom-up practices to deal with uncertainties, risk everything to help citizen clients, and make informed judgments and evidence-based decisions to achieve better work outcomes or minimize policy failures adaptively (Cohen & Cohen, 2023; Cohen & Golan-Nadir, 2020; Gale et al., 2017; Howlett, 2009).

Purpose of the Study

This dissertation builds on and extends the framework developed in Bredenkamp (2022) (please see **Appendix A**). This dissertation places peer support in context within the stories nurses tell about their work. The goal is to compare the impact of peer support from nurses in various public hospital settings. Beginning with the premise that organizational support among peers — relationships, shared motivation, and shared commitment — may indirectly enhance public service delivery, this dissertation recognizes the significance of peer support and relational factors in comprehending how nurses deliver care. Peer support often serves as many

nurses' "first line of support" for maintaining professional confidence, thriving and performing well in the workplace, and providing quality public hospital services. In exploring this working proposal, the aim is to study an iconic example of SLBs: nurses who work in mental health nursing, military nursing, and emergency room nursing.

Significance of the Study

This study contributes to scholarship by employing narrative methodology as an analytical tool to contextualize SLBs' peer support in various emotionally charged healthcare settings. Nurses were selected as study participants at the intersection of SLBs, peers, and clinical settings because they are the largest frontline public health workers who provide government-funded health services to the public every day (Lipsky, 2010). Mental health, military, and emergency nurses were chosen for three reasons. First, their work situations cannot be reduced to standard bureaucratic procedures. Every day at an emergency room, military base, or mental health facility is unique, necessitating task contingency such as higher certifications or hours of supervised clinical practice for nurses to adapt and respond to new and complex situations (Wilson, 1989). Second, peer interaction among these nurses is more than just social interaction; it is an interchange of clinical expertise that affects the quality of care they provide (Lotta & Marques, 2020). Finally, the peer experiences of these nurses reveal their professional identities and organizational practices. Peer experiences enable nurses to recognize a set of social norms (or institutional logics) in hospital settings that impact their professional choices in various contexts (Sperling et al., 2022). These nurses' professional actions are then the result of appropriate passed-down behaviors from clinical peers (March & Olsen, 1995).

This intangible, passed-down aspect of healthcare "is necessarily relational and only has meaning within a chain of relationship, which is an ongoing process of identification that emerges in and through narratives" (Watson, 2006, pp. 509-510). Narratives in this context are "acted rather than told" stories that reflect the present, rather than the past, of direct experience among nurses and their social and professional environments (Hurwitz et al., 2004, p. 74). Such direct experiences contribute to a better understanding of "people as active social beings" and place attention on how nurses' personal and professional realities are formed, enabled, and hindered in dialogues with peers (Smith et al., 2009, p. 343). As Bakhtin (1984) proposes, dialogue requires people to abandon self-sufficiency and embrace self-discovery through the stories of others.

Study Organization

This study collects and interprets narratives to "humanize [policy] and organizational studies by focusing on social actors," such as mental health, military, and emergency nurses (Brown & Thompson, 2013, p. 11).

This dissertation is organized into six chapters to help the audience better grasp these social actors' lived experiences or narratives. The first chapter provides context for the research, the problem statement, the study's purpose, and the significance of the study. This chapter also demonstrates the significance of peer support theory and argues why it warrants further exploration in relation to street-level bureaucracy theory. This chapter further offers an overview of the research question and purpose, along with an introduction to the dissertation's structure.

The second chapter reviews the literature to situate the study within a broader framework of street-level bureaucracy, peer support, institutional logics, intrinsic drive, professional purpose, and organizational commitment. Additionally, this chapter provides a critical analysis of existing research, identifies gaps in the literature, and lays the groundwork for this study by developing a peer support conceptual model. This model serves as a guide for contextualizing peer support across varied nursing settings.

The third chapter describes the narrative analysis methodology, which elucidates the participants' lived experiences or narratives, as well as the research question, research design, participant selection procedure, inquiry processes, and study validity. This chapter further offers a clear and comprehensive overview of the use of Clandinin and Connelly's (2006) narrative inquiry, the purposive sampling strategy used to select this study's participants, and the justification for their suitability and validity in addressing the research question and purpose.

The fourth chapter summarizes the findings, including the distinctive narratives of the mental health, military, and emergency nurses in this study, their varied conceptualizations of peer support, and the influence of peer support on their jobs. Moreover, this chapter presents, analyzes, and interprets the results of this study to give voice to this study's participants, identify major emerging themes, and highlight any unexpected or interesting findings that emerged during the analysis. Such analysis and interpretation are also conducted to contribute to the existing body of knowledge and advance the understanding of peer support in varied nursing settings.

The fifth chapter discusses the findings by threading together the narratives of mental health, military, and emergency nurses alongside pertinent research literature. This chapter

synthesizes and interprets this study's findings to provide insights into their theoretical and practical implications. Also, this chapter examines the themes shared by the different types of nurses in this study to reflect how they co-support quality care through professional meaning and establish accountability for themselves and their peers. This chapter further discusses the performative and transformative power of hybrid peer support and the formative effect of peer support, both of which can help healthcare organizations refocus on developing and retaining competent nurses within a supportive environment.

The sixth chapter concludes this dissertation by summarizing the findings, drawing conclusions, and discussing implications for future research. This chapter provides a concise overview of the research findings and reinforces the key takeaways from the study. This process discusses how the findings contribute to existing knowledge, advance theoretical frameworks, and inform practical applications. For example, this chapter revisits this study's peer support conceptual model based on a hybrid peer support program to present a model that has the potential to impact the healthcare system positively. Such a model aims to create and recreate the conditions necessary for nurses at all stages of their careers to feel supported and thrive at work.

CHAPTER TWO: WHAT IS PEER SUPPORT AND WHY IT IS IMPORTANT?

Introduction

This chapter explains the essence of peer support and its importance as a concept. This chapter briefly outlines how two forms of peer support — formal or preceptorship and informal or mentorship — offer unique forms of guidance and support to nurses, complementing their professional care interventions and deliveries. Formal peer support or preceptorship provides an opportunity for new nurses or nurses transitioning to new specialty areas to acquire hands-on clinical expertise and refine their clinical skills under the supervision of a preceptor or experienced nurse. Whereas, informal peer support or mentorship brings firsthand lived experiences to the forefront, proving practical advice, coping strategies, and peer-tested solutions that may not be readily available through formal channels. While distinguishing and comparing these two forms of peer support, this chapter underscores that a peer-driven approach to support empowers nurses to take an active role in managing their own well-being, building resilience, and developing skills for overcoming challenges while effectively supporting peers and patients. Furthermore, peer support holds significant importance in the healthcare system as it provides a unique avenue for nurses to connect, empathize, and learn to enhance the quality of patient care.

This chapter is organized to discuss peer support as the theoretical framework. This chapter reviews the street-level bureaucratic theory and its relationship to peer support and institutional logics, emphasizing the relevance of discretion, peer support, and organizational norms on the frontlines and in the nursing field. This chapter concludes by illustrating the value

of peer support in nursing and how it enables nurses to exhibit professional purpose and organizational commitment through intrinsic drivers, peer support, and peer collaboration.

Peer Support and Street-level Bureaucrats

Lipsky (1980) describes public servants such as nurses, police officers, and teachers as "street-level bureaucrats" (SLBs). Lipsky's (1976, 1980, 2010) studies on SLBs continue to be a reference point for SLB research because of their enduring relevance and comprehensive insights into the dynamics of frontline public service delivery. Lipsky's work sheds light on the unique challenges, constraints, and discretionary powers SLBs face in their day-to-day interactions with clients. By examining the role of SLBs as frontline agents of public policy implementation, Lipsky provides a nuanced understanding of how organizational structures, resource constraints, and external pressures shape bureaucratic decision-making and service provision at the street level. SLBs and frontline workers are synonymous in this research. Lipsky's studies offer valuable theoretical frameworks and conceptual tools for analyzing the behavior and experiences of SLBs in various contexts. Through his exploration of the concept of "discretionary authority," Lipsky highlights the inherent tension between formal rules and the practical realities of public service delivery, emphasizing the role of SLBs in interpreting and applying policy guidelines in situational contexts. Additionally, Lipsky's notion of "task discretion" underscores the importance of SLBs' autonomy and judgment in adapting policies to meet their clients' diverse needs and circumstances. By elucidating these key concepts, Lipsky's studies provide researchers with analytical lenses for understanding the complex interplay between organizational structures, SLBs' agency, and external influences in shaping frontline public service provision. Lipsky's studies continue to inform policy debates and discussions

surrounding optimizing public service delivery and enhancing frontline worker effectiveness. By highlighting the challenges and dilemmas SLBs face in meeting their roles' demands, Lipsky's work stresses the importance of supporting and empowering frontline workers to navigate complex and dynamic public service settings and policy implementation. Creating a supportive and collaborative workplace that promotes the development of SLBs is a critical determinant of appropriate discretionary use and effective policy implementation (Hickey et al., 2013; Shamian & El-Jardali, 2007). Discretion is using a degree of freedom on public services to limit or expand government benefits to give people hope of just and fair government treatment (Lipsky, 2010; Maynard-Moody & Musheno, 2003, 2012).

For Lipsky (1980), discretion at the frontline turns SLBs into policymakers by applying regulations in complicated and unusual circumstances, making judgments about individuals and situations, and improving citizen clients' well-being (p. 15). Focusing on the interests and well-being of citizens is also what makes frontline discretion the fundamental reason why delivering public services entails more than just policymaking. For example, recent work revises Lipsky's framework of SLBs as policymakers by arguing that SLBs do not perceive themselves as policymakers. Maynard-Moody and Musheno (2003, 2012, 2022) have been leading voices in this tradition of scholarship, emphasizing the distinction between state-agent and citizen-agent narratives. A state-agent narrative situates discretion within the characteristics of a rational bureaucratic rule of law. In contrast, a citizen-agent narrative incorporates the stories and practical experiences of SLBs, where interdependence on peer support improves moral judgments, professional meaning, organizational socialization, fairness, and agency (Cohen & Golan-Nadir, 2020; Hupe & Hill, 2007; Maynard-Moody & Musheno, 2003, 2012; Siciliano, 2017; Walker & Gilson, 2004). For example, Cohen & Golan-Nadir (2020) use focus groups and

one-on-one interviews to collect data from 30 Israeli police officers to show they develop solid bonds and solidarity with their peers through shared experiences and challenges. This sense of solidarity, they contend, creates a supportive and interdependent environment where officers are willing to take risks to protect and support their fellow officers in dangerous situations. Also, as an expansion of their theory, Maynard-Moody and Musheno (2022) added the knowledge agent narrative, bringing forward social characteristics such as workplace climate and norms and their influence on SLBs and citizen encounters. For example, they emphasize how social exchanges and willingness to learn and change practices and norms to meet the needs of citizens shape the workplace climate, professional norms, and new decision-making processes (Maynard-Moody & Musheno, 2022, p. 176). In this vein, SLBs perceive themselves as citizen agents rather than policymakers who focus on who individuals are and what peers say in regard to their imagined selves and prioritize caring and cultural adherence above legal adherence (Maynard-Moody & Musheno, 2012, p. 517).

In this perspective, SLBs' "biological potential for caring for the welfare of others is not only innate but also develops with experience and interactions with peers" (Cohen & Golan-Nadir, 2020, p. 483). This type of organizational interaction or socialization among peers leads to the development of professional identity/meaning, relationships, collaboration, trust, norms, knowledge, social support system, agency, and organizational commitment (Keulemans & Van de Walle, 2020; Van Maanen & Schein, 1977). Peer interaction as a support system plays a vital role in facilitating individual actions or SLB agency through comprehending the work environment rules/norms, transferring information, experiences, and values, and effective use of professional discretion. This peer interaction and support is facilitated by the effective use of professional discretion, allowing nurses to be competent when providing services to patients and

commit to their organizations because their work roles are the result of direct contact with peers' experiences and organizational contexts (Van Maanen & Schein, 1977). For example, experienced nurses exercise discretion to critically support new nurses in shaping their professional identity by helping them understand their own assumptions, beliefs, practices, and workplace culture — allowing new nurses to grow confidence over time (Parker et al., 2014; Zarshenas et al., 2014). Moreover, Johannessen (2017) conducts an ethnographic study on nurses' discretionary application of guidelines when determining the severity of patients' conditions using data from triage interactions in a Norwegian emergency department. The study's findings reveal that nurses' patient assessments are based on pragmatism and experience rather than guidelines. The study also shows that nurses utilize guidelines as a foundation for their evaluations but deviate from them to gather additional information, rely on emotion and agency, and allow peers or patients to influence their decisions. Furthermore, Brenne et al. (2023) performed semi-structured interviews with 15 home care nurses in Norway to explore how their professional discretion is enacted in practice. These interviews aim to uncover how nurses navigate the tension between meeting the needs of their clients and adhering to the policies and procedures set forth by the purchaser-provider split model. The purchaser is often the local government, whereas the provider is frequently a private or nonprofit organization. The study demonstrates that nurses exercise discretion to carry out extra work to foster a flexible and competent patient-centered service culture. Indeed, by examining the discretion exercised by American emergency physicians and nurses in triaging high-risk trauma patients, Schellenberg et al. (2023) claim that nurses exercise discretion in emergency rooms to effectively identify patients who are more likely to need emergency surgery to save their lives. Similarly, after conducting 102 in-depth interviews with doctors and nurses in Israel to examine the cultural

impact of informal or “under-the-table” payments on their behaviors, Cohen (2018) contends that nurses use discretion to support peers and make exceptions for patients when they favor citizen clients and believe it benefits the greater good and advances the healthcare mission of saving lives.

Discretion in nursing is essential when it allows nurses to support each other with experience and expertise for competent public service delivery. Competent care delivery for this study’s mental health, military, and emergency nurses is task contingent. The nature of SLBs’ or nurses’ tasks, as Wilson (1989) asserts, determines what public hospitals do and why they deliver effective care. He further explains that many factors influence tasks, including peer expectations, prior training, and organizational culture. An organization’s culture is a socially constructed system of values, principles, and behavioral norms that guide employees’ behavior (Hofstede et al., 1990; Schein & Schein, 2016). There has been growing acknowledgment of the interconnectedness between task relevance and organizational culture in shaping employee experiences. According to Wilson (1989), the interaction between task and culture is continuous because “every organization has a culture, that is, a persistent, patterned way of thinking about the central tasks within an organization” (p. 91). In other words, organizational culture impacts the way organizational members operate. For example, the National Aeronautics and Space Administration’s 1986 Space Shuttle Challenger and 2002 Space Shuttle Columbia incidents were caused by its culture (Guthrie & Shayo, 2005). Therefore, the organizational culture of this study’s mental health, military, and emergency nurses profoundly shapes how they perceive support and approach their tasks and roles in delivering care.

In this view, public service entails the connection between a practice or task, the practice’s setting, the practitioner’s role, and the interactive and supportive bond among

practitioners, which can lead to developing a sense of community (Goodsell, 2015). Several studies find that this sense of community founded on work experiences and support strongly relates to nurses' feelings of belongingness and organizational commitment (Azeem & Akhtar, 2014; Meyer & Allens, 1997; Newstrom, 2007). Such organizational commitment characterizes nurses' work as peers supporting one another in the delivery of effective healthcare. As Mead and colleagues (2001) put it, "peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and an agreement of what is helpful" (p. 6). Beyond giving and receiving, peer support enables nurses to self-manage by developing skills through formal and informal training and internalizing necessary professional attitudes and values through mentorship to ensure effective and consistent care delivery. The SLB literature has largely overlooked the positive impact of peer support indirectly on public service delivery. Nonetheless, Walker and Gilson's (2004) study examines the experiences, attitudes, and behaviors of nurses implementing policy in South Africa's urban healthcare system. Based on 10 in-depth interviews and 113 questionnaire responses, the study asserts that peer support plays a determinant role in helping SLBs cope with difficulties raised by daily work to deliver services effectively. Also, based on research on why SLBs risk their lives for others, Cohen and Golan-Nadir (2020) contend that the effectiveness of policy implementation and the role of SLBs depends on their codependency on peer support. They mention, for example, that police officers are extremely close because of their interactions with peers, and they risk their lives to support peers due to organizational ideologies or institutional logics.

In their perspective on the policy implementation continuum, recent scholarship employing institutional logics perspectives emphasizes the importance of organizational logics or ideologies on the behavior of SLBs. Institutional logics are defined as "the socially constructed,

historical pattern of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (Thornton & Ocasio, 1999, p. 804). The institutional logics that prevail within a specific organization will significantly impact how its members interact, share information, behave, and make decisions (Thornton et al., 2012). Institutional logics guide actions, interactions, and interpretations within organizations, allowing members to perform their tasks (Ocasio, 1997). For example, according to the service-dominant logic of public service, institutional norms, normative frameworks, and structures influence public value co-creating (Vargo & Lusch, 2016). Public value, according to Moore (1995), is citizens' collective expectations regarding public services. Service-dominant logic in the public sector enables co-creating public value by emphasizing procedures that strengthen the interaction and interdependence between public service providers as peers and promote the well-being of citizen clients (Doring & Carty, 2021). Consequently, service-dominant logic promotes high-quality interaction and peer support, resulting in a climate of interpersonal trust, mutual respect, psychological safety, and high team-level productivity in delivering complex and interdependent tasks in public healthcare (Vashdi, 2013). However, the healthcare system is characterized by the infusion of multiple institutional logics stemming from diverse healthcare values and demands, each exerting varying degrees of influence on how healthcare professionals, such as nurses, exercise their responsibilities (Van den Broek, Boselie & Paauwe, 2017). For instance, healthcare policies and practices encompass government-established societal level logics (Currie & Guah, 2007). Healthcare professionals, including nurses, physicians, and administrators, engage in an ongoing process of interpreting and re-interpreting these logics to inform their practices, tailored to their specific tasks and settings. This iterative process is non-linear, as new

and existing logics often clash and coalesce within the dynamic and evolving healthcare landscape. Consequently, this dissertation delves into the institutional logics influencing SLBs or nurses' behaviors.

Scholarship on institutional logics indicates that peer support and organizational norms provide psychological safety and trust, which can impact SLBs' behaviors (Brodkin, 2011; Tummers et al., 2012). The behaviors of SLBs, such as nurses, are significantly influenced by peer support (Fleming, 2020). For example, Lyman, Gunn, and Mendon (2020) use semi-structured interviews with 13 inpatient hospital new graduate nurses to argue that new nurses experience psychological safety and trust when they feel supported by their peers with work-related and personal needs, that their voice is heard, that they are comfortable asking questions, and that errors are viewed as opportunities for professional development. Also, one of the powerful determinants for SLBs to engage in prosocial rule-breaking or making exceptions is their willingness to support peers (Morrison, 2006) and conform to public organizational norms such as social meaning (Tummers et al., 2012). Social meaning relates to the SLBs' belief that government policy adds value and contributes to society as a whole (Van Engen et al., 2016). In this way, social meaning enables SLBs to be altruistic and support others for the greater good. Altruistic behavior empowers nurses to support peers in saving patients' lives and improving their psychological well-being by realizing the direct impact of their actions and the meaningfulness of government policy. For example, O'Donovan and McAuliffe (2020) systematically review the psychological safety literature review, using 36 peer-reviewed articles published between 1999 and 2019, to demonstrate that peer support influences nurses' psychological safety as a form of social exchange and support. They claim that peer support is critical for nurses' psychological safety because it enables them to learn organizational norms,

maintain strong interpersonal and collaborative relationships with peers, and reinforce doing the right thing to save lives. Furthermore, in the nursing literature, Boykin and Schoenhofer (2001) aim to enhance understanding of the central role of caring in nursing and its implications for patient care, professional development, and healthcare outcomes in their book titled *Nursing as Caring: A Model for Transforming Practice*. They argue that the lifeblood of effective public health service delivery is peer support because it promotes a high level of social or intimate relationships among nurses, resulting in relational responsibilities to face limited resources, unsafe and uncertain job environments, and value-laden high work demands to promote person-centered care. Also, peer support solidifies nurses' socioemotional abilities (i.e., empathy, emotional regulation, and emotional labor), which leads to better job performance, less emotional fatigue, and higher motivation, resulting in more effective care delivery (Nasurdin et al., 2018; Rousseau et al., 2009).

In recent years, there has been a notable surge in attention toward the concept of "emotional labor" within organizational contexts. Emotional labor is the process of regulating emotions as part of one's job tasks, particularly in service-oriented industries such as healthcare (Guy, Newman & Mastracci, 2008). With the recognition of the significant impact of emotional labor on employee well-being and organizational outcomes, researchers and practitioners alike have begun to emphasize the importance of understanding and managing emotional labor effectively. Studies such as those conducted by Grandey (2000), Brotheridge and Lee (2003), and Mastracci, Guy, and Newman (2012) have shed light on the various strategies organizational members and nurses employ to navigate emotional labor demands, highlighting the need for organizations to implement supportive policies and practices to mitigate the negative consequences associated with excessive emotional labor. As organizations continue to prioritize

employee well-being and productivity, attention to peer support within organizational culture has become increasingly imperative in helping nurses navigate the complexities of their tasks. For example, “during times of conflicting values, [nurses] may depend on [the support] of coworkers to provide the type of care that nurses know is right to give” (Longo, 2011, p.8). In this context, peer support has been used among nurses to regulate emotional labor (Cricco-Lizza, 2014), promote retention (Rudel, 2006), pass down knowledge, elevate individuals’ competency, and affect health outcomes (Dennis, 2003). The World Health Organization (1998) stresses this point of view by recognizing that cultivating social relationships is a health promotion strategy because it provides mutual aid and supportive resources and environments.

Based on the literature, this dissertation suggests that such a supportive environment relies on three notions of peer support. First, the notion of care and being professionally forged (professionalism) by life experience and formal means (Van Maanen & Schein, 1977). This notion is fundamental in nursing. For example, nurses often acquire their understanding of care and professionalism through a combination of life experiences and training, such as preceptorship. These trainings provide nurses with the information, skills, and ethical concepts they need to provide safe and effective care. Furthermore, life experiences can impact a nurse's understanding of care by developing empathy, compassion, and the capacity to connect with patients and meet them where they are individually.

Second, the idea of experiencing the clinical settings through the stories or experiences of peers or mentors and seeing and hearing informally in clinical settings (Zarshenas et al., 2014). Experiencing clinical settings through the stories and experiences of peers, for example, as well as informal observations is an integral part of nurses' professional development. Nurses often share stories and experiences with each other during formal debriefings, informal conversations,

or through shared experiences during patient care. These peer interactions provide valuable insights into different approaches to patient care, challenges encountered, and successful strategies for addressing them. Learning from peers provides valuable learning opportunities, fosters a sense of community and support, and contributes to cultivating competent, compassionate, and resilient nursing professionals.

Third, the feeling that supervisors are unsupportive is important in peers supporting one another (Maynard-Moody & Musheno, 2003; Tuckett et al., 2015). The perception of unsupportive supervisors can significantly impact nurses' well-being and care delivery process. The support of peers plays a critical role, especially in environments where supervisor support may be lacking. Peers can offer emotional, practical, and professional support, promoting resilience, camaraderie, and positive work culture among nursing staff.

Finally, as explained above by the three notions, formal training through preceptorship, informal learning through mentorship, and peer support are critical for nurses' effective care delivery. In this vein, these three notions are the prerequisites for the two ideal types of peer support that govern effective care delivery: preceptorship or formal peer support and mentorship or informal peer support. While both formal and informal peer support plays valuable roles in supporting the professional development of nurses, they differ in duration, structure, initiation, goals, and evaluation.

Formal Peer Support

Preceptorship is defined as “a formal, one-to-one [peer support] relationship of predetermined length, between an experienced nurse (preceptor) and a novice (preceptee) designed to assist the novice in successfully adjusting to and performing a new role” (Canadian

Nurses Association, 2004, p. 13). Preceptorship allows preceptors to help preceptees formally perform their daily nursing jobs and navigate through clinical challenges. In fact, Piemme et al. (1986) emphasize that a critical role of preceptors is to help preceptees set and achieve goals, identify their nursing values, and evaluate their skill development to perform effectively. Friedman and colleagues (2013) also use data from new nurses before and after a year-long preceptorship program in pediatric critical care, emergency department, and hematology/oncology to show that effective preceptorship programs increase nurses' retention and decrease turnover. Kim (2007) further examines data from 102 senior nursing students who completed a 160-hour clinical preceptorship program. She finds that preceptees associate the preceptorship experience with having meaningful feedback about their performance, identifying strengths and weaknesses, increasing competency, and having greater confidence. Moreover, Ferreira and colleagues (2018) analyzed data from 6 preceptor nurses to assess nurses' knowledge and competencies for preceptorship in basic health units. They claim that preceptorship is vital in mediating between theory and practice, allowing nurses to be competent professionals who collectively reflect in practice to create professional meaning and perform well. As a result, they argue that competent nurses become high performers who are more committed to narrowing the gap between life and death for patients. Also, Aparício and Nicholson's (2020) systematic review of peer-reviewed articles published between 2009 and 2019 finds that preceptorship programs increase new nurses' competence, confidence, performance, and retention rates.

However, Kramer's (1993) critique of preceptorship is that it is hierarchically structured and implemented in a top-down process. This top-down approach does not adequately support preceptors (Panzavecchia & Pearce, 2014). For example, the top-down preceptorship structure is

guided by irregularities in preceptor selection and preparation, “as well as pressures to conform to the curriculum and traditional academic calendars,” which may high-jack the informal interaction and relationship needed to support preceptors and preceptees (Sedgwick & Harris, 2012, p. 2). As Burke (1994) indicates, preceptorship will be a confusing training and less practical teaching experience without the informal collaboration between preceptors and other clinical professional bodies. The clinical environment also may not be suitable for the preceptorship’s short-term learning objectives because patients stay for short periods of time, there is a shortage of experienced nurses who precept, and the available experienced nurses are overworked and do not have time to precept effectively. The limitations of formal peer support suggest that informal peer support may provide additional professional support for nurses.

Informal Peer Support

Penney (2018) sees peer support as an informal, intrapersonal, and social giving and receiving system that nurses use to understand each other through shared experience or responsibility and mutual consent of what is necessary for care. “Maintaining [an informal peer support] vantage point is crucial in helping [nurses] rebuild their sense of [belonging], community,” and commitment to the nursing role and organization (Mead & MacNeil, 2006, p. 4). According to Mohamed, Newton, and McKenna’s (2014) analysis of 437 registered nurses’ workplace belongingness in Malaysia, this sense of belonging and organizational commitment are critical elements that help nurses understand their role, feel supported or validated, avoid burnout, and reach a degree of competency for higher levels of quality care delivery. Oberfield (2014), Siciliano (2015), and Fowler (2021) all echo this competency paradigm, indicating that peer support can help SLBs and nurses cope with the uncertainties of healthcare delivery. They

suggest that nurses are likely to informally complete tasks professionally and competently since their work roles are the product of their direct contact with peers' experiences. Longo (2011) explains how a nurse perceives peer support when a nurse states that "we kind of live and die by how much we help each other… [that allows us] to attend to patients and provide competent care" (p. 11). Bae (2011) examines international nurses' perceptions of organizational socialization and compares them to US-born nurses to see how peer support allows new nurses to stay at their jobs for over three years. Using a proxy variable and a module, he uses a survey dataset of 752 nurses conducted between June 2006 and September 2007 to measure their willingness to depart within three years. He finds that new foreign-educated nurses had higher organizational socialization than new American-educated nurses. New foreign-educated nurses also tend to remain after three years due to peer support exercised as informal mentoring.

Peer support in the form of informal mentoring pertains to an unstructured relationship that lasts longer than preceptorship and is based on mutual acknowledgment and personal development needs (Tourigny & Pulich, 2005; see **Table 1** for more information). Vidal and Olley (2021) synthesize the existing literature of articles published between December 2015 and December 2020 on the effects of mentorship on new nurses' clinical performance and work satisfaction/retention. As a result, they argue that informal mentoring is more effective than precepting because it "brings about long-term effects that transcend into the quality of professional competence and relationships [while increasing mentees'] job satisfaction, retention, and clinical performance" (p. 11). Such informal mentoring helps mentees to have an organizational commitment (Weng et al., 2010), be autonomous, self-directing, and competent in providing adequate care (Harris, 2017).

However, peer support as an informal mentoring can be challenging and draining within a mental or public health care setting, especially in the early stage for mentors and mentees when it lacks structure and mentors are overworked with less time for mentees (Smith, McAllister & Crawford, 2001). In other words, without a structured mentoring program, both mentors and mentees may have unclear expectations about their roles and responsibilities. This ambiguity can lead to confusion and frustration since both parties may need help fully understanding what is expected of them. Subsequently, mentoring relationships may be inconsistent and discontinuous. For example, mentors may not have time or resources dedicated to their mentees, leading to inconsistent support. This inconsistency can hinder the mentee's development and undermine the effectiveness of the mentoring relationship.

Table 1: Difference Between Preceptorship and Mentorship

	Preceptorship - Formal Peer Support	**Mentorship - Informal Peer Support**
Duration	Short-term commitment (Canadian Nurses Association, 2004)	Long-term commitment (Tourigny and Pulich, 2005)
Choice of supporter	Preceptors are appointed not chosen, and allocated to, rather than chosen by preceptees.	The new clinical professionals (mentees) select the experienced professionals (mentors) as an appropriate resource through a process of confidence development.
Goal	Develop clinical skills and fitness for practice. The preceptor's job differs from mentoring in that it focuses on the topic to be addressed rather than the new graduate's experience in practice.	Enable the development of professional confidence. A mentoring relationship supports clinical professionals adapt to new environments or experiences. Employers may not establish or sustain this relationship.
Structure	Ascribed and hierarchical	Flexible-negotiated between the parties
Initiating and	The organization determines the duration, which might range from one	By mutual and negotiated consent.

ending	or two weeks to many months.	
Evaluation	Formal written assessments, performance evaluations, or competency checklists. Feedback is often provided by both the preceptor and the preceptee's supervisor.	Performance evaluation is less formalized and may rely on subjective and inconsistent assessments of progress and mutual satisfaction. Feedback is exchanged informally through conversations, reflections, and ongoing interactions between the mentor and the mentee.
Reason for public health leaders	Response to reality shock in the US. Support transition; role mastery and socialization.	Response to workforce concerns both at the performance and the retention levels. Transition to practice is one of the key concepts attached to mentoring (Vidal and Olley, 2021)

Source: Modified table from Lennox, Skinner, and Foureur (2008).

Peer Support: Intrinsic Motivation, Professional Meaning, and Organization Commitment

While formal peer support stresses hierarchical preceptorship and supervision to support preceptees, informal peer support focuses more on mentorship in creating a supportive environment for mentors and mentees. Despite their different roles, significant findings grounded in nursing research aim to bridge the gap between formal and informal peer support to create a culture of wellness that prevents emotional and physical burnout in nursing. In this context, peer support is vital because it connects the formal educational relationship that bridges the theory-practice divide to the informal supporting, inspiring, and nurturing environment. This connection enables experienced nurses (preceptors and mentors) and new nurses to thrive, be competent, and stay at their jobs (Armitage & Burnard, 1991). The goal of peer support, in this case, is to encourage nurses to maximize their potential by developing intrinsic motivation through the use

of three intrinsic motivation drivers: autonomy, mastery, purpose (Norton, 2018), and accountability.

Autonomy

According to Norton (2018), autonomy is defined as the ability to act freely on one's own judgment, which "can increase engagement and personal ownership in a way that leads to renewed vigor" (p.5). Although nursing practices are based on obtaining a license to have legal authority and freedom, it is a self-governing profession that thrives on relational autonomy. From a relational perspective, autonomy is more than mere freedom because it manifests as actions and results from supportive social conditions such as peer support in nursing (MacDonald, 2002). Moore and Cagle (2012) state that peer support is critical in the early years of completing nurses' formal training and the preceptorship training goals to allow them to be autonomous. Furthermore, Longo's (2011) findings, based on data from 13 nurses in a Southeastern university nursing program, indicate nurses' perceptions that, despite extensive formal education, they seek skills and knowledge validation through peer support (preceptorship and mentorship). Research on social learning theory has proven that experiences and imitation are how individuals learn (Bandura, 1977, 1986). Also, as Murphey and Jacobs (2000) suggest in their theory-building review essay, learning is "intermentally constructed" between peers to reach autonomy based on sociocultural theory. In this scholarly tradition, autonomy is conceptualized as learning not independently but interdependently because it stems from an established mental reality among a sociocultural group, such as nurses, that if one fails a patient, they all fail. This positive interdependence goes beyond teamwork and can be compared to a sense of support commonly seen in communitarian cultures.

Autonomy, in this sense, "demands an intense interaction between health professionals …so the professionals can respond adequately to the demands and to face the uncertainties present in the moments of interaction" for practical and effective actions (Melo et al., 2016, p.2). This intense interaction among nurses creates supportive conditions – both personal and technical – that allow them to act on their professional judgment confidently (Donchin, 2000). Such judgment is formed when "peer support is more than just a conversation" among SLBs because it promotes mental health and allows them to learn clinical best practices (Milliard, 2020, p. 1). In this vein, interaction or learning to reflect on one's nursing practices among peers increases crucial nurses' soft skills through respect and empowerment, leading to the development of their professional identity and necessary nursing skills (Jassim, Carlson & Bengtsson, 2022). Consequently, peer support is a critical teaching and learning tool that enables nurses to experience less burnout (Vahey et al., 2004) and have more autonomy (Norton, 2018) in using relevant information from peers to deliver adequate care (Dennis, 2003). Autonomy is then a critical factor in nursing because it strengthens nurses' clinical knowledge and confidence to have the freedom to act in clinical situations (Pursio et al., 2021; Skår, 2010).

Mastery

Professional actions in nursing have a profound impact when nurses demonstrate enthusiasm and mastery. Mastery in nursing entails exhibiting developed competencies and control in stressful clinical situations to make a difference (Younger, 1991). Norton (2018) draws on his US Marine Corps experience, healthcare experience, and motivation literature to contend that "the drive toward mastery in a profession that makes a difference in the world [of nursing] is a foundation for motivation that can also help prevent burnout" (p. 6). DeCicco (2008) also

evaluates data from 27 participants in Saint Elizabeth Health Care's distinctive preceptorship and mentoring program, which includes preceptors, preceptees' managers, clinical resource nurses, and health services supervisors. As a result, she argues that developing less burnout, capable, and competent nurses necessitates a continuous formal or preceptorship and informal or mentorship peer support model that invests in frontline nurse development. Peer support has been shown to be an effective tool in assisting nurses in navigating through difficult professional clinical situations and creating professional meaning. For example, Carvello et al. (2019) studied data from 14 emergency nurses in Italy to examine their lived and clinical experiences with peer support. According to their findings, peer support helps emergency nurses cope with the emotional traumas associated with emergency medical situations, allowing them to remain mentally healthy and thrive at work. Professional meaning in nursing is associated with a sense of professional autonomy, belief in self-regulation and public service, and dedication to the nursing profession (Tanaka et al., 2016). As Otway (2001) discovers, in her qualitative and quantitative study of 350 nurse prescribers to determine their clinical development needs, peer support was essential for nurse prescribers to learn new skills, improve existing skills, refocus their public servant belief, and skillfully master prescribing medication.

Mastery, or the feeling that nurses have the necessary skills to control their practices or surroundings, is a powerful cognitive dimension that is linked to intrinsic motivation (Deci, 1971). Nurses become intrinsically motivated by the nature of their service, which is to serve the public, as they gain mastery, experience, and self-efficacy (Auger & Woodman, 2016). In fact, contemporary public administration emphasizes mastery through collaboration among peers to better meet the needs of citizen clients (Vigoda, 2002). Research on trauma-informed principles finds that employees thrive in organizations that emphasize positive psychological mechanisms

such as peer support, trust, and collaboration in ways that connect intrinsic motivation, self-efficacy, mastery, and organizational commitment (Norton, 2018). Similarly, based on 19 new nurses data, Komaratat and Oumtanee (2009) use quasi-experimental instruments to argue that a model of mentorship with a twist of preceptorship or formality types of peer support can help harness the power of nurses' competency and mastery, leading to purposefulness and individual and healthcare breakthroughs.

Purpose

The primary outcome of autonomy and mastery is purposefulness. The commitment to one's identity, goals, and organizational goals is referred to as purposefulness (Norton, 2018). Public organizations generally come with bureaucratic monitoring and control that tend to slow down public servants. The most important aspect of peer support is that it allows the formation of "cohesive networks among peers to facilitate norm enforcement, allowing the replacement of traditional and costly organizational control mechanisms with more efficient, norm-based organizational control modes" (Tamer & Dereli, 2014, p. 179). In other words, peer support networks are often more cost-efficient to maintain compared to traditional organizational control mechanisms, such as supervision, monitoring, and disciplinary procedures. Peer support relies on existing social relationships and informal peer interactions, requiring fewer resources and administrative oversight to operate effectively. Also, cohesive peer networks are often called purpose-oriented networks because they are more flexible and adaptive in identifying efficient ways "to improve the design and delivery of goods and services in public health" (Yang & Nowell, 202, p. 350).

Research on peer support further suggests that peer support is positively associated with organizational commitment (Mottaz, 1988; Mueller et al., 1999). For example, Van Emmerik and colleagues (2007) employ multilevel analyses of data from 2,773 constabulary officers to determine that peer support buffers unsafe workplaces, resulting in increased job investments. Similar to this study, Eisenberger and colleagues (1990) use data from 237 different occupational groups, including high school teachers, university resident assistants, brokerage firm clerks, manufacturing workers, insurance representatives, and police officers, to argue that organizational support allows employees to feel physically and psychologically comfortable enough to commit to an organization. Stinglhamber and Vandenberghe's (2003) longitudinal study, which included 245 Belgian university employees from 1988 to 1997, finds that feeling at ease within an organization as a result of organizational or peer support leads to the development of employee self-esteem, emotional satisfaction, and emotional attachment to a workplace. Finally, Allen and Mayer (1990, 1996) emphasize that organizational attachment or commitment generates some level of employee support because highly committed employees identify with their organization and remain at their workplace for longer.

In sum, research on peer support above shows that it leads to three important elements: autonomy, mastery, and purpose. The interaction of these elements defines the impact of peer support on clinical experiences and practices in nursing. Peer support, in this sense, stresses empowerment, identity construction, role competence development through collaboration and self-confidence, higher performance, and retention (Cottingham et al., 2011; Greene & Puetzer, 2002; Scandura & Hamilton, 2002; Schroyer et al., 2016: Van Patten & Bartone, 2019). For example, the Hackensack University Medical Center (HUMC) in New Jersey implemented a

peer support program, resulting in high-performing nurses, quality care delivery, and nurses waiting to enter their workplace (**s**ee **Table 2**).

Table 2: HUMC Peer Support

HUMC is a 635-bed, not-for-profit, tertiary-care, teaching and research hospital serving northern New Jersey and New York, USA. Located just seven miles west of New York City, and with more than 63,000 inpatient stays and 1.7 million outpatient visits a year, HUMC is one of the busiest hospitals in the nation. Nevertheless, at HUMC, there is a waiting list of nurses who wish to work there.

"We have never wavered in our support of the nurse at the bedside," says Toni Fiore, MA, RN, CNAA, executive vice president for patient care and chief nursing officer. Fiore also states that "you have to have complete support from the top. Our president, John Ferguson, has always believed strongly in our nurses, and has always been their champion."

Goldberg, responsible for organizational education at HUMC, says that through these training programs they have specifically targeted specialties in which it is often hard to recruit enough nurses. "We have excellent preceptor programs in oncology, bone marrow transplant, and in women and children's health and medical-surgical," she says. "Nursing students who train in these areas often decide they like it and come back to us when they are ready to begin their nursing careers."

Mentoring is an important component of the nursing program, and Fiore says it is enormously beneficial for both young nurses and more experienced ones. "You put these young, energetic nurses in an environment with nurse leaders who work with them, listen to them, and really walk the talk about nursing excellence, and it raises everyone's standards and expectations of themselves," she says.

The results are HUMC measurable successes such as:

- A vacancy rate that is essentially 0. "Maybe it's 2 or 3 percent," says Fiore, "but we are always effectively fully staffed.
- Nursing staff that is 100 percent employed by HUMC. The hospital does no foreign recruitment, does not use "traveler" nurses (who fill in for up to 13 weeks), and does not contract with nursing agencies.
- 6.3 percent voluntary turnover among Registered Nurses.
- Eleven-year average Registered Nurse length of service.
- A satisfaction rate among nurses in the 97th percentile as measured by Press Ganey.
- A ratio of 70 Registered Nurses to 30 clinical support staff in medical-surgical areas.
- An average ratio of 80:20 in critical care units.

Source: Institute for Healthcare Improvement (2008)

Accountability

The definition of accountability in nursing has been linked to the concepts of autonomy, mastery, authority, and responsibility through purposefulness (Snowdon & Rajacich, 1993). According to the American Nurses Association's Code of Ethics for Nurses (2015), nurses are accountable for self-care, accountable to their peers, and "responsible for the quality of their practice" (p. 15). The service quality perceived by patients depends on nurse autonomy, mastery, purpose, resilience, and work environment (Tanaka et al., 2016). Nurses with autonomy, mastery, and purpose recognize that nursing can be stressful physically and emotionally. These nurses seek strategies to improve their resilience, described as adapting well when faced with considerable stress. Linton and Koonmen (2020) use Watson's Caritas theoretical processes to argue that the two most effective strategies these nurses use to improve resilience are "having one-on-one discussions with colleagues [about work] and participating in informal socialization with colleagues outside the work environment" (p. 1697).

Improving resilience helps these nurses be accountable for their work and their peers and provides a healing, teaching, and learning environment for their peers. Linton and Koonmen (2020) indicate that these healing environments allow peers to develop their competence, feel comfortable, and experience emotional safety. Emotional safety in nursing depends on reciprocal emotion management, also known as interpersonal emotion management, which involves assisting others in coping with their emotions and is predicated on the premise that others will reciprocate over time (Lively, 2000). Rafaeli and Sutton's (1987) study on the emotional socialization of physicians effectively explains how interpersonal emotion management drives interactions and instruction among healthcare professionals. They describe the experiences of a female medical intern who cried about patients during her first month as a medical student. She

was labeled a highly emotional woman who would never be a good doctor. They then explain how interacting with, observing, and learning from medical students and more experienced physicians helped her realize which emotions should be experienced and demonstrated to others, emphasizing cultural norms and healthcare institutional logics. Erickson and Grove (2008) then mention that knowing the profession's emotional norms is crucial since "the expectation of having to manage one's emotions is frequently more destructive than [the performance of emotional labor itself] (p. 713). As healthcare research on emotional labor has shown, nurses experience emotion at work. However, nurses with autonomy, mastery, and purpose accept emotional labor as part of their work and choose to routinely prioritize peer support by being accountable for improving emotional resilience for themselves and creating healing environments for peers with lessons about cultural and organizational expectations to maximize potential patient health outcomes. Emotional labor research within the public administration domain strongly supports this assertion. For instance, Mastracci, Newman, and Guy (2010) contend that proficiency in emotional labor, attained through emotional resilience or emotive skills, is vital for fostering peer support. Such skills form the cornerstone of public service, facilitating the creation of healing environments characterized by compassion, empathy, and productivity.

Finally, peer support at the street level is a two-sided tool. On the one hand, it is about demonstrating one's emotional resilience and competence, as well as collaborating with others to create a supportive and healthy workplace. In healthy organizations, a peer plays a vital role in shaping another peer's professional and organizational commitment. On the other hand, it is an invitation to support others, give others a voice, share ideas, and work together to create an

environment of healing, meaning, relationships, recognized performances, and quality public services.

Conclusion

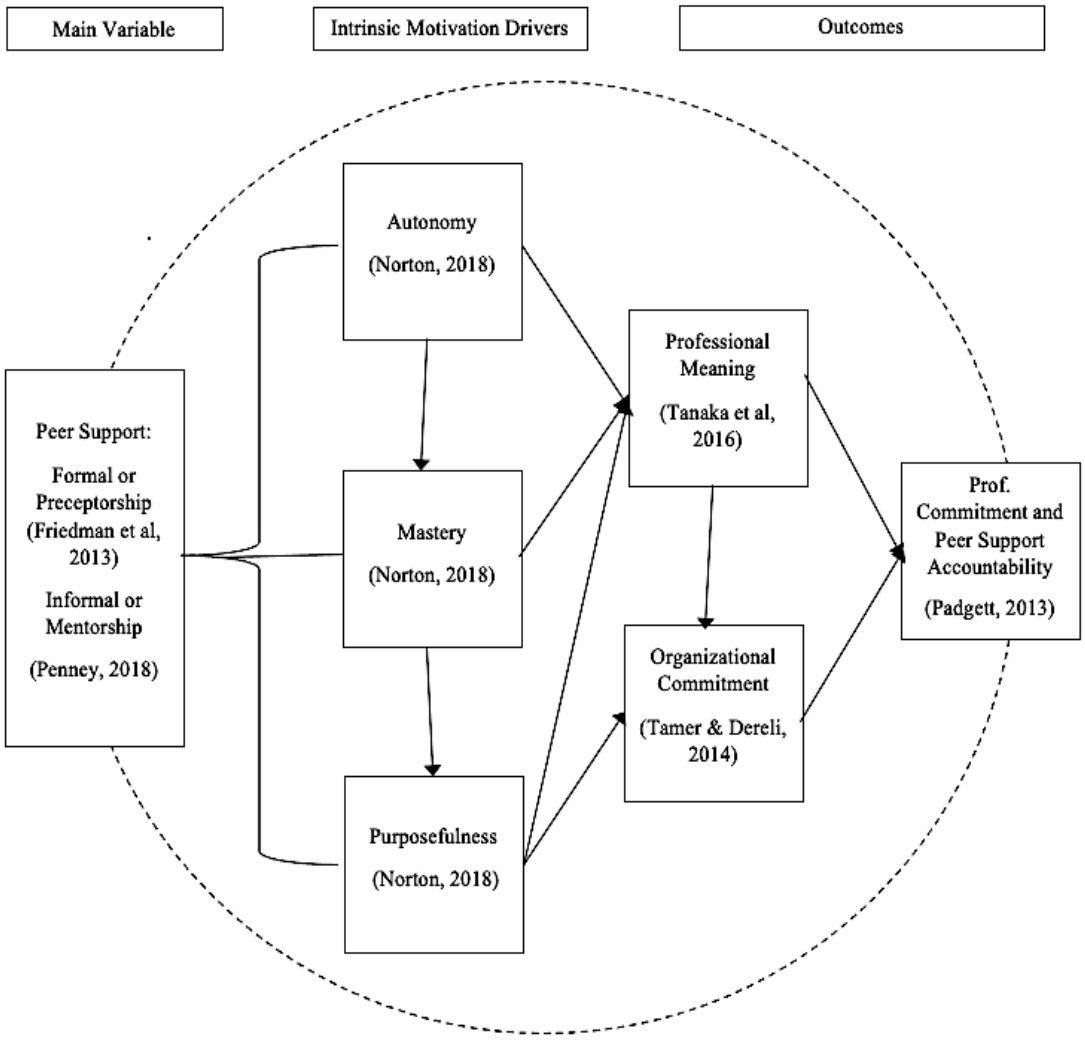
This chapter starts with a review of the scholarships above in discussing the concept of peer support in relation to street-level bureaucracy and intuitional logics perspective. The concept of peer support in nursing shares notable parallels with the street-level bureaucracy theory, particularly in the context of frontline healthcare delivery. Peer support networks among nurses operate as informal support systems where nurses as frontline workers collaborate, share knowledge, and provide emotional support to one another. Within these networks, nurses negotiate competing institutional logics, such as medical professionalism, bureaucratic regulations, and patient-centered care, as they strive to balance the diverse demands and expectations of peers, patients, and organizations. The institutional logics perspective provides insights into the broader institutional context within which peer support networks operate, highlighting the influence of institutional norms, values, and structures on professional practice and organizational behavior. As frontline behaviors, nurses exercise discretion and decision-making autonomy in their daily patient interactions, often relying on peer relationships to navigate complex healthcare systems. Within these networks, nurses negotiate competing institutional logics, such as medical professionalism, bureaucratic regulations, and patient-centered care, as they strive to balance stakeholders' diverse demands and expectations. The institutional logics perspective provides insights into the broader institutional context within

which peer support networks operate, highlighting the influence of institutional norms, values, and structures on professional practice and organizational behavior.

The following chapter uses the theoretical framework presented in this chapter to recruit and collect data through interviews with mental health, military, and emergency nurses at public hospitals. By listening to the stories of mental health, military, and emergency nurses, this study aims to elevate the voices and lived experiences of peer support's anticipated and surprising influence on their professional meaning and organizational commitment. Through the stories of nursing professionals across the mental health, military, and emergency settings, this study seeks to contextualize peer support. Therefore, this study is guided by a conceptual model (see **Figure 1** below) that I developed to visually describe the relationships between intrinsic motivation drivers in contextualizing the role of peer support.

Figure 1: Peer Support Conceptual Model

Peer support promotes interpersonal relationships among nurses through informal and formal shared experiences or expertise to encourage nurses to optimize their intrinsic motivation drivers. Optimizing these drivers includes developing intrinsic motivation in three ways: autonomy, mastery, and purpose, as illustrated in the diagram below (Norton, 2018). Chapter 2's review of scholarship shows that the positive interplay between these drivers leads to professional meaning and organizational commitment because peer support stresses empowerment, professional identity building, and role competency growth through cooperation. Furthermore, with professional purpose and organizational dedication comes accountability in nursing, which involves being accountable for their work and peers. Finally, accountability to peers leads to a cyclical loop in which nurses return to peers what they received as peer support.



→ Positive relationship
----- Positive cyclical process

CHAPTER THREE: STORYTELLING METHODOLOGY

Introduction

This chapter discusses the study's method of narrative inquiry. Methods, according to Bryman (2004), refer to research approaches such as storytelling or interviews rather than the epistemological and ontological positions underpinning a research question. This exploratory research will use a qualitative method called narrative inquiry. Narrative inquiry offers a valuable approach to exploring nursing perceptions about peer support, as it allows nurses to share their experiences, insights, and reflections in their own words. Through storytelling, nurses can convey the complexities of their relationships, interactions, and experiences with peer support in a nuanced and contextually rich manner. By inviting nurses to narrate their experiences with peer support, this study aims to capture the diverse perspectives, voices, and lived realities of the frontline nurses of this study. Also, this study uses narrative inquiry to promote reflexivity and dialogue with its findings among nurses, researchers, and healthcare administrators, fostering a collaborative approach to understanding and addressing issues related to peer support in nursing. By engaging mental health, military, and emergency nurses as active participants in this research process, narrative inquiry empowers them to shape the narrative discourse surrounding peer support and advocate for changes that enhance its effectiveness and impact.

This chapter is organized by first reintroducing the research question. Second, the research design section explores best practices for narrative inquiry analysis in public administration and justifies this study’s use of narrative inquiry, notably Clandinin and Connelly’s (2006) framework. Third, the participants’ section provides crucial information about

this study's sampling strategy and participants. Fourth, the data collection section describes the processes of emailing and meeting virtually with this study's interview participants. Lastly, the inquiry process's section discusses this study's data analysis process and validity.

Research Question

This dissertation puts mental health, military, and emergency nurses at the forefront of this research by listening to their voices through their stories to understand how the nuanced exchange of clinical advice/expertise or peer support between nurses may impact their perspective of their profession and the quality of their work. This dissertation research question is: *How does peer support affect nurses' cultivation of professional meaning and organizational commitment in different work settings?*

Research Design

Narrative inquiry has been a significant qualitative tool in advancing research on clinical practice (Alhonsuo, Sarantou & Miettinen, 2022; Davidhizar & Lonser, 2003; Drumm, 2013). Narratives refer to stories about professional experience "with a plot that ties together different parts into a meaningful whole" (Feldman et al., 2004, p.148). In the last few decades, public administration scholars have taken a "narrative turn" to capture rich experiences and stories that could inform public administration and policy challenges. This narrative turn has been influential due to the narrative analysis or inquiries that affected several social science disciplines like economy (Brown, 1994), political science (Cohen, Jones & Tronto, 1997), and public administration (Roe, 1989). Different schools of thought have different narrative inquiries in public administration. Interpretivists (e.g., Riessman, 2008) believe that stories should be

preserved as a whole, not fractured into themes, to help researchers understand the intention and action of study subjects when creating meaning. On the other hand, positivists (e.g., Abbott, 1992) take stories to generate temporal sequences statistically.

Despite this diversity, four primary public administration narrative-based studies have made novel contributions to the public administration and policy literature. These studies are the Narrative Policy Analysis (Roe, 1994), Narrative Policy Framework (Jones & McBeth, 2010), *Cops, Teachers, Counselors: Stories from the Front Lines of Public Service* (Maynard-Moody & Musheno, 2003), and the three-part series in *Public Administration Review* by Ospina and Dodge (2005a, 2005b) and Dodge, Ospina, and Foldy (2005). These studies share the narrative inquiry methodology using similar in-depth, open-ended, and unstructured interview processes to collect stories and employ content analysis. However, this paper focuses on a similar interpretive framework of Maynard-Moody and Musheno (2003) in preserving stories as a whole to convey the meaningful experiences of cops, teachers, and counselors. They interviewed 48 participants and collected 158 stories in total. The structural and content elements serve as the coding foundation for these stories, allowing the authors to expose context sentences with identical codes. However, they contend that the fragmented and coded sentences are not meaningful on their own because they are part of the whole story (p. 177). In other words, fragmented and coded sentences, when taken out of the whole story context, often lack coherence and fail to convey a clear message on their own. These sentences are typically part of a larger narrative, contributing to developing characters, themes, and plotlines. Without the surrounding context, fragmented and coded sentences may appear disjointed or confusing, making it difficult to understand their intended meaning. Consequently, while these sentences may contain elements of symbolism and

metaphor, their actual value and impact emerge when they are situated within the broader context of the story.

In organizational theory, narrative analysis is more than a coded and fragmented sentence of events; it needs narrative elements “such as focal actors, narrative voice, evaluative context, and other context indicators” to tell the whole story and influence organizational processes (Pentland, 1999, p. 721). Stories, for example, shape processes by giving meaning to events by enabling actors to enact in ways that emphasize their education, experience, and culture, all of which are essential drivers for socialization and organizational culture expression. In this respect, stories, unlike traditional data, allow for the observation and measurement of correlations between antecedents and consequences by putting processes, events, actions, and actors at the center of analysis and drawing conclusions about the intervening causal sequences of events. As a result, Pentland (1999) contends that narrative enables empirical social scientists to tell the whole story of an organization or a person as a process.

Exploring whole stories or narrative analysis to provide information rarely found in interviews and to experience multiple perspectives from healthcare professionals or patients has been exercised in the health and illness field. For example, Haigh and Hardy (2011) discuss how stories can influence healthcare delivery by changing clinical practices. They specify that while storytelling may be used in other organizations to reflect or transfer norms, it provides a window into healthcare actions and experiences. In fact, in their endeavor to widen the scope of evidence-based practices by reflecting the elements of peer support, MacNeil and Mead (2006) suggest that "the practical knowledge of peer support will require adopting a narrative framework" (p. 17). In this dissertation, I intend to use stories to describe nurses' actions and experiences while providing healthcare services. In doing so, I hope to demonstrate how storytelling can put social

relationships and peer support at the center of healthcare delivery, and how nurses rely on peer experiential knowledge to grow professionally and address changing health needs.

Unlike Maynard-Moody and Musheno (2003) and other narrative research in public administration, this dissertation will concentrate on the whole stories as acted on or performed narratives rather than the stories as told. “Performed narratives are not retrospective accounts of past events but living narratives that involve the active shaping of present moments” (Hurwitz et al., 2004, p. 74). Performed narratives then play an important role in clinical care by sharing what happens during peer encounters and how that encounter serves as a chapter in a larger narrative, a story of care and support that saves citizens’ lives. To better convey the performed narratives of this study’s participants, this dissertation employs Connelly and Clandinin’s (2006) narrative framework, which is based on the following three story elements: “sociality, temporality, and place.” They define sociality in stories as the personal (i.e., feelings and reactions) and social (i.e., interactions and environmental norms) dimension, temporality as the experience era, and place as the physical setting.

This framework allows this study to emphasize healthcare organizational processes through peer support in three significant ways. First, this framework enables this study to focus on the nurses' story elements that underpin their social interactions since their understanding of peer support is intertwined with their identity, organizational norms, and interactions with peers. Second, it allows this study to examine nurses' experiences in several dimensions, concentrating on the past, present, and future. Finally, it permits this study to investigate practical knowledge construction through peer support, with an emphasis on the location or organization where the job is being performed. This emphasis is significant because knowledge creation is embedded within organizational settings and culture.

Participants

This qualitative study uses Riessman's (2008) interpretative conception of design. This concept offers the foundation for data collection and analysis in examining nurses' work within the personal, emotional, relational, physical, social, and organizational context. Purposive sampling, a technique for selecting individuals with rich information about the investigated topic, was used to collect data or stories from any mental health, military, and emergency nurses who convey context on peer support (Thorne, 2008). I posted a Google form survey (see **Appendix B**) on Facebook and LinkedIn, inviting public hospitals' mental health, military, and emergency nurses to participate in this study. The post explains that I intend to collect my dissertation data from volunteer mental health, military, and emergency nurses to highlight the importance of peer support in public health and the necessity for peer support to enhance and retain nursing talents. The post also asks volunteers to complete and distribute the survey as necessary. The post further promises a $20 Amazon gift card once volunteers complete the interview process. I also included my contact information in case potential participants have any questions.

Potential participants responding to the announcement shared their name, email address, nursing specialty, gender, geographical location, the hospital system where they work, how long they have worked there, years of experience in the nursing profession, and preceptorship and mentoring experiences.

After receiving 238 responses from people who wanted to participate in this study, the Google form stopped accepting responses from potential participants in September 2023. Potential participants were identified and contacted by email from the list of respondents

through a seven-step process. This process began with 1) organizing respondents based on their specialty, 2) their preceptorship and mentorship experience, 3) their geographical location, 4) their race and gender, 5) their present employment experience, and 6) using their IDs to verify their credentials; as well as 7) scheduling an interview.

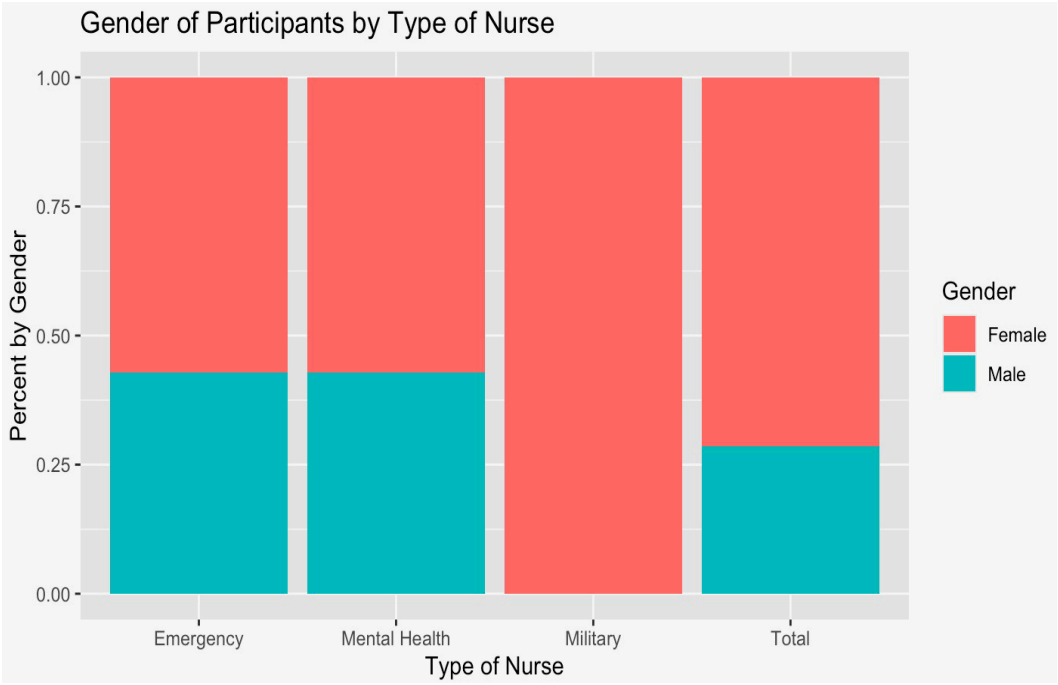
Furthermore, a few potential participants did not respond to the emails or only answered after the selection process was completed. Also, a few of them could not attend the interview and did not participate in the research. Therefore, 21 nurses — 7 military nurses, 7 mental health nurses, and 7 emergency room nurses — were chosen based on their responses to Google form questions about their indication to participate in either formal (preceptorship) and informal (mentorship) peer support, locations, nursing specialties, gender, race, years of experience in their workplace, and willingness to prove their legitimacy as nurses. This process was necessary to exclude 217 nurses who did not have preceptorship or mentorship experiences and to create racial, cognitive, and geographic diversity to capture new and experienced nurses' perspectives on peer support from different points of view, races, workplaces, and states. Additionally, the 21 selected nurses indicated they had at least 1 to 2 years of work experience in their current hospital. Having one or two years of experience in their current workplace is crucial for this dissertation because it allows the assumption that a year or two is sufficient time for nurses to become socialized and familiarized with their workplace culture, which can have a significant impact on peer support as well as professional and organizational commitment. Please see **Table 3** below for their anonymized initials, type of nurse, race, gender, and years of nursing service.

Table 3: Participants' Initials, Occupation, Gender, Race, and Years of Nursing Service

Participant Anonymized Initials	Type of Nurse	Gender	Race	Range of Years of Nursing Service
AB	Mental health nurse	Female	Black	3 to 6
HW	Military nurse	Female	Black	3 to 6
DT	Mental health nurse	Male	Black	2 to 4
OP	Emergency nurse	Male	White	7 to 15
PT	Military nurse	Female	White	6 to 12
QE	Emergency nurse	Female	Black	3 to 6
GA	Mental health nurse	Female	Black	1 to 2
FM	Mental health nurse	Male	Black	3 to 6
JD	Military nurse	Female	White	12 to 24
OB	Military nurse	Female	Black	4 to 8
RD	Emergency nurse	Male	Black	3 to 6
DM	Military nurse	Female	White	10 to 34
CB	Emergency nurse	Female	Black	5 to 10
NZ	Emergency nurse	Female	Black	2 to 7
CV	Military nurse	Female	White	6 to 12
MM	Military nurse	Female	Multiracial	4 to 8
ZW	Mental health nurse	Female	White	3 to 6
VT	Mental health nurse	Male	Black	3 to 6
UV	Emergency nurse	Female	White	1 to 2
SB	Mental health nurse	Female	Black	4 to 8
GM	Emergency nurse	Male	Black	2 to 5

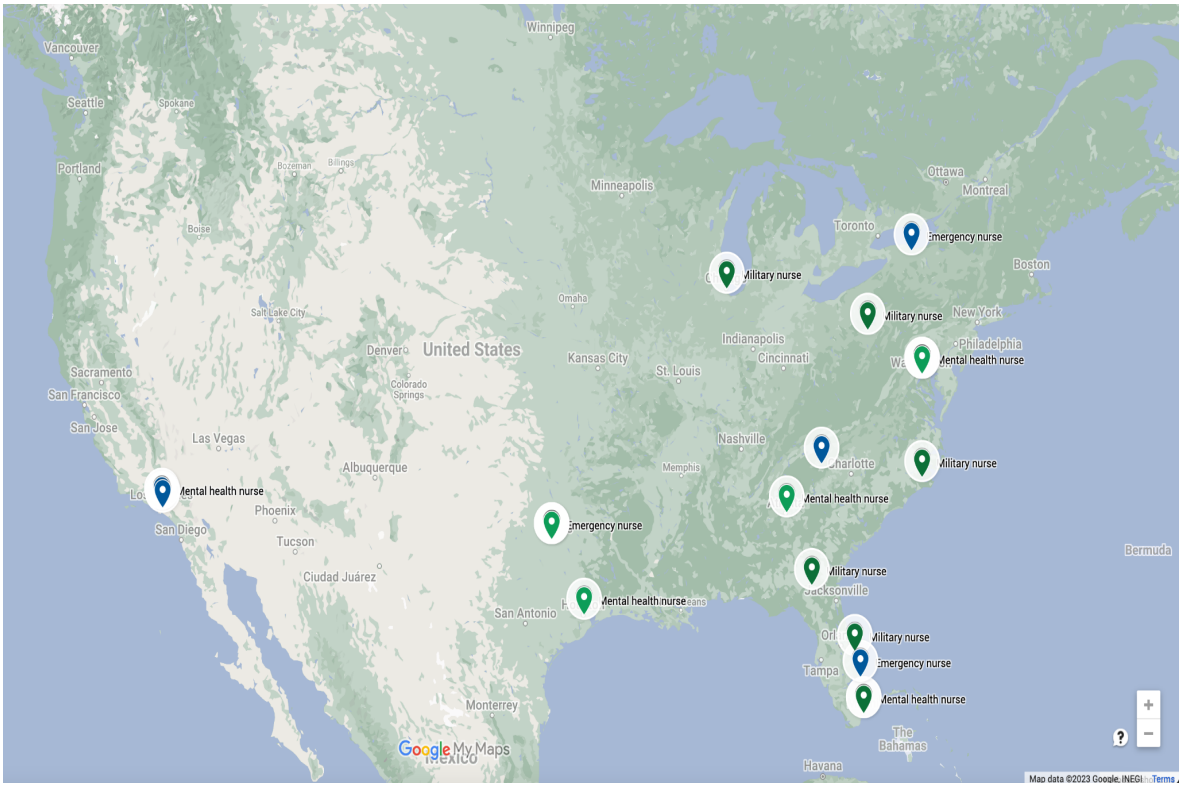
To ensure participants' anonymity, as specified in this dissertation's IRB, the 21 selected nurses were given anonymized initials and a range of experiences, as shown in **Table 3** above. Furthermore, **Figure 2** below illustrates that the study included 6 men and 15 women. The graph also shows that male nurses were evenly split among mental health and emergency nurses, while all military nurses were female.

Figure 2: Gender of Participants by Type of Nurses



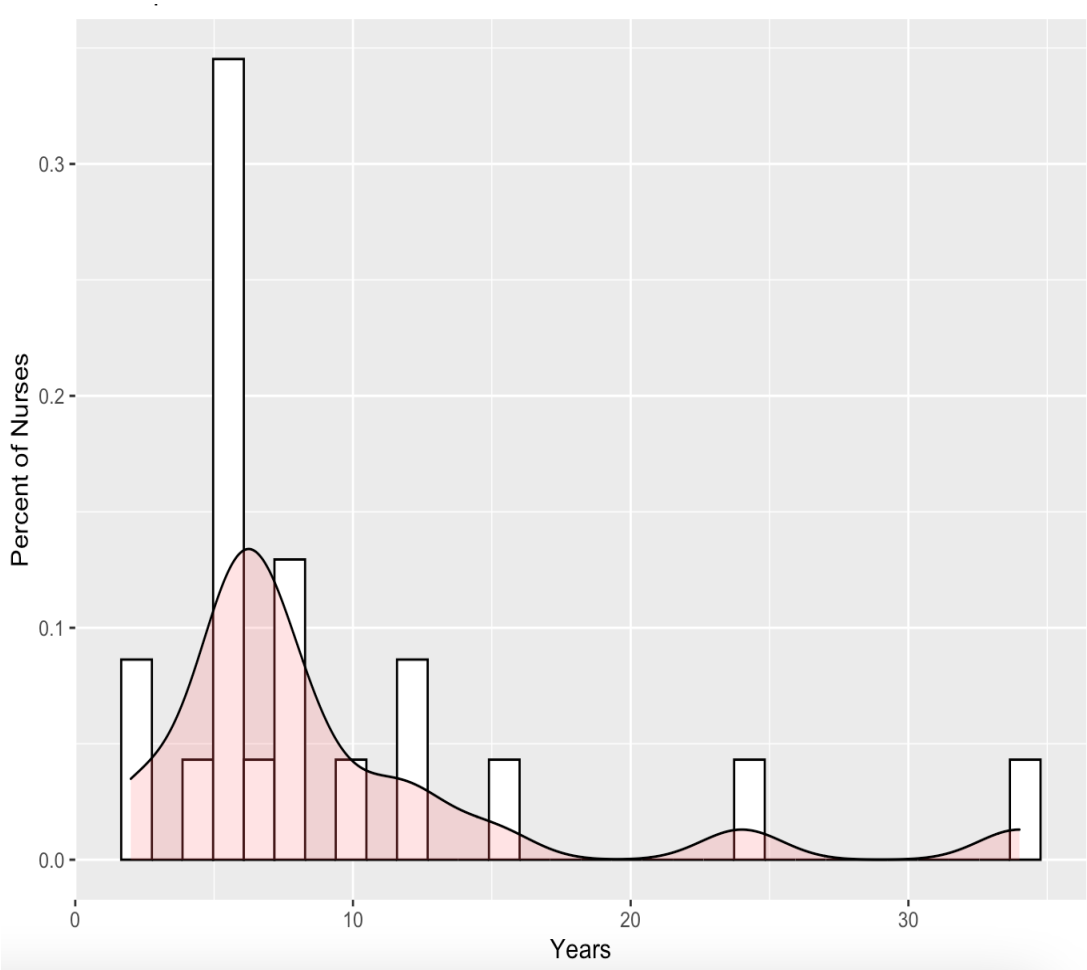
After accounting for participant gender, there were some demographic variations among mental health, military, and emergency nurses. Two mental health nurses resided in Texas, two in Washington, DC, and one each in Florida, Georgia, and California. Two military nurses lived in Pennsylvania, two in Florida, one in Washington, DC, one in North Carolina, and one in Illinois. Two emergency nurses lived in Texas, two in California, and one each in Florida, New York, and North Carolina. Briefly, the 21 nurses ranged in age from 25 to 60 and came from 10 states. Four participants were from Texas, four from Florida, four from California, three from Washington, D.C., two from Pennsylvania, two from North Carolina, one from Georgia, and one from Illinois (see below **Figure 3**).

Figure 3: Locations of Different Types of Nurses



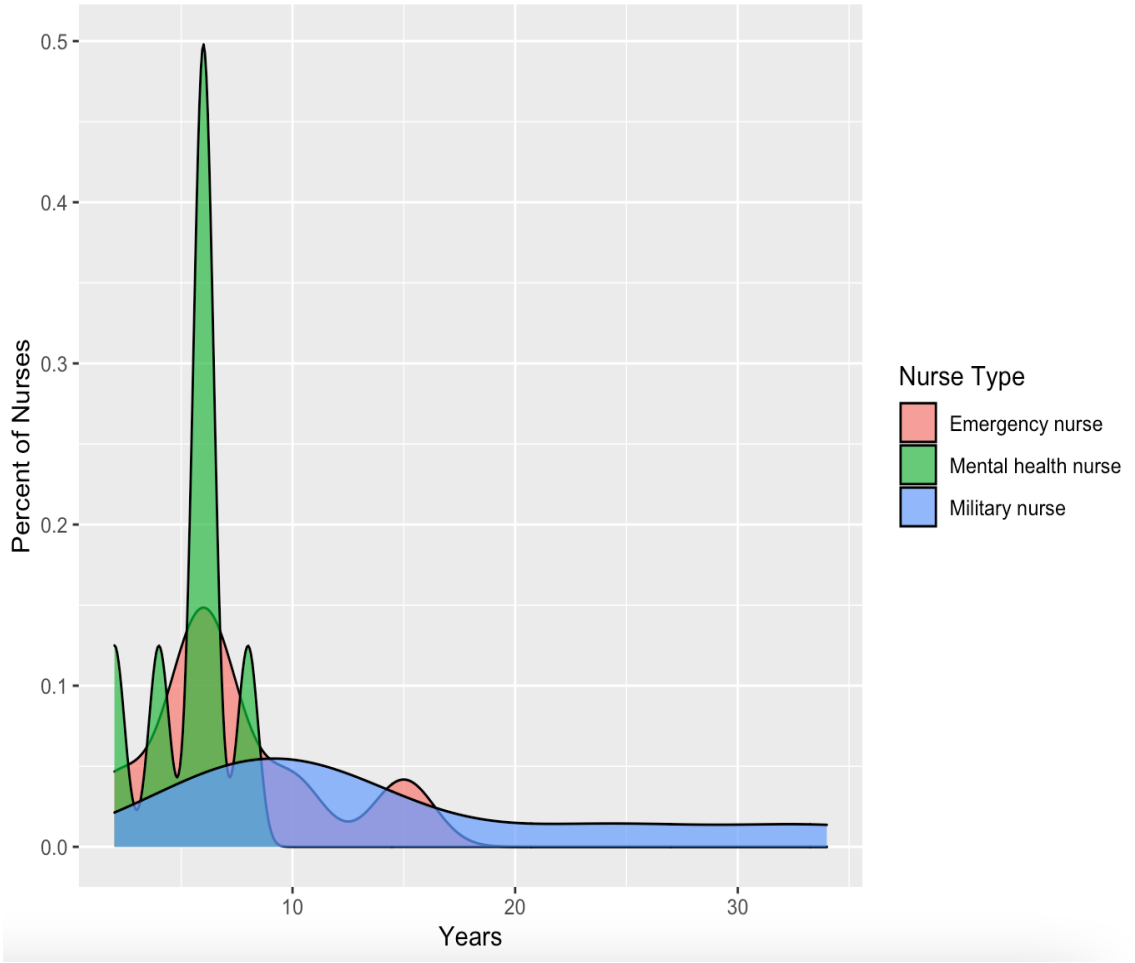
Mental health, military, and emergency nurses' experience levels differ. Military nurses had experiences ranging from 3 to 34 years, emergency nurses from 1 to 15 years, and mental health nurses from 1 to 8 years. Overall, these nurses' average length of employment is 6 years. The diversity of this study's participants' nursing experience, ranging from 1 to 34 years, is crucial for this dissertation since it allows it to capture the narratives of both new and experienced nurses (see **Figure 4** below).

Figure 4: Participants' Average Years of Service



Furthermore, when we look at the data by nursing occupation and based on this participant sample, military nurses have a longer career span, followed by emergency nurses, and mental health nurses have a younger and shorter career span (see below **Figure 5**).

Figure 5: Participants Career Span Per Nursing Occupation



Finally, the lived experiences of these nurses are essential to this dissertation because they all participated in a preceptorship or mentorship program. They all worked in public hospitals and were regularly exposed to stressful events such as unexpected death and trauma. They all meet Lipsky's definition of SLBs. The primary goal of recruiting SLBs like these nurses

was to explore the impact of peer support on nurses' professional meaning and commitment to better serving the public.

Data Collection Process

Informed Consent and Transcription

After receiving IRB 23- 692 approval on June 23, 2023, I circulated a Google form via Facebook and LinkedIn to solicit research volunteers. After receiving consent from volunteers for their willingness to participate in the study via Google form, I sent them a recruitment email (see **Appendix C)** to schedule interviews (see interview questions in **Appendix E**) dates on the cloud video conferencing platform Zoom, along with an information sheet (see **Appendix F**) detailing the purpose, risks, benefits, and process of the research study. At the individual interviews on Zoom, I verbally introduced the study to acquire their verbal consent.

The verbal introduction form (see **Appendix D)** provided a full description of the interview's voluntary and confidential nature, anonymity with identifying number, audio recording, and deletion of personal identifying information. The above data collection occurred through a 2-stage process. In the first stage, 1) I posted a Google survey form online, 2) selected eligible participants, 3) sent recruitment emails, 4) distributed Information sheets, and 5) sent follow-up emails to schedule interviews. In the second stage, I conducted 45 to 60-minute semi-structured interviews via Zoom (See **Appendix G**).

All interviews were recorded and verbatim transcribed using Zoom automated transcription. In addition, all interviews were revised for grammatical quality and sense-making using interview recordings. Field texts, including interview recordings and transcripts, are

password-protected and saved on Google Drive. At the same time, reflexive researcher notes from twenty-one Zoom interviews are protected on a cloud-based technology called Delve, which is discussed in greater detail below.

Inquiry Processes

Data collected consisted of face-to-face Zoom interviews and researcher notes. As indicated in Chapter Three, this study applied Connelly and Clandinin's (2006) narrative inquiry methodology, which is similar to Maynard-Moody and Musheno's (2003) interpretive approach. In the next section, details are outlined for how the terminology and concepts behind their approaches are incorporated into this dissertation.

Narrative Inquiry Setting

The narrative inquiry setting, according to Connelly and Clandinin (2000, 2006), creates a relational and conversational space where researchers can explore lived experience through a three-dimensional analytical lens of time, social interaction contexts, and place, bringing research participants' contextual experiences to life. This setting allows researchers to appropriately study healthcare professionals' developmental processes by "thinking with stories" (Clandinin, Cave & Berendonk, 2017, p. 89). For example, Wong and Trollope-Kumar (2014) think with stories in their narratives inquiry into medical learners' professional identity building to show that medical students' professional identity formation is shaped through active interactions with peers, patients, and mentors.

Given that this line of thinking with stories evolves over time, Clandinin and Connelly's narrative inquiries went from narratively reflecting the knowledge of teachers to narratively

retelling the context in which teachers develop professional identities and knowledge (Clandinin & Connelly, 2004). Such narrative inquiry evolution necessitates experience and improved interpretation skills. Maynard-Moody and Musheno (2003) use their interpretive narrative inquiry experiences, similar to Clandinin and Connelly (2006), to give voice and meaning to the — experiences of police officers, teachers, and counselors. Furthermore, Clandinin, Pushor, and Orr (2007) suggest that integrating the following three story elements — sociality, temporality, and place — clearly explain research participants' authentic and lived experiences.

By listening to the stories of this study's participants, this study aimed to create a setting that elevates their voices and lived experiences. Connelly and Clandinin's (2006) narrative framework is important because it enables this study to use sociality, temporality, and place to reflect the stories of emergency, mental health, and military nurses about the impact of peer support on their jobs. As a narrative researcher working in the public administration framework, I began my inquiry by staying faithful to my participants' stories and giving them a voice. My responsibilities included creating a relational and safe setting to collect detailed stories. These stories were then collected in a remote setting (interviews took place over Zoom on the participants' preferred days), a time (at the participants' convenience), and a trusting environment created by verbal consent and confidentiality agreements. This environment is crucial because it enables both participants to tell stories using an evaluative framework and this study to use an analytical framework to reflect what is seen through participants' stories, all of which can impact organizational change and supportive processes in the healthcare setting. (Pentland, 1999; Connelly & Clandinin, 2006).

The data collection and field text generation occurred between the beginning of July 2023 and the end of December 2023. A number of factors contributed to the study duration. First, I

needed to make certain that they met the study requirements specified in the Google Form survey, as they would be critical for my dissertation. After receiving 238 responses and closing the study announcement in September 2023, the steps taken to ensure the potential participants met the dissertation criteria were 1) organizing respondents based on their specialty; 2) their preceptorship and mentorship experience; 3) their geographical location; 4) their race and gender; 5) their present employment experience; 6) using their IDs to verify their credentials; 7) scheduling an interview. Second, because nurses have busy schedules, I wanted to ensure I gave them many week and weekend days and times to choose from for the interviews. Finally, I wanted to take my time cleaning, reading, and analyzing my data while still leaving room for me to contact participants with fresh memories of their stories if there was any further inquiry.

Data Analysis

I created field texts by collecting background and geographical information while also interviewing 21 nurses via Zoom. Because narrative interviews allow participants to be the narrator and the researcher to be the listener, the interview method was semi-structured to allow participants' unique stories to come through. In that way, narrative interviews are open and fluid, allowing for the formation of rich stories (Maynard-Moody & Musheno, 2022).

Following the interviews, I downloaded Zoom audio recordings and transcripts from Virginia Tech’s canvas media and placed them on my Google Drive in a password-protected folder. I then began reviewing and rewriting transcripts and, if required, listening to audio to clean up the transcripts. During the cleaning phase, I erased any participants’ personal information and took notes to help me construct threads later in the coding process. This study uses the coding foundation of Maynard-Moody and Musheno’s (2003) stories, which is based on

structural and content elements, which allowed the authors to expose context sentences with identical codes. I utilized Delve, a cloud-based qualitative data analysis software, to perform coding. Delve's intuitive interface helped me to rapidly piece together my transcripts and bring to light story insights. In finding developing themes and patterns in these stories, this dissertation used an inductive analytic technique and a thematic analysis based on Riessman's (2008) approach to conduct open content, structural, and axial coding procedures. I conducted a reflexive thematic analysis on Delve as described by Braun and Clarke (2019). Reflexive thematic analysis, according to Braun and Clarke (2019), is based on the belief that themes do not emerge passively from data. They argue that themes emerge through a recursive coding process combined with a deep, reflective, and thorough engagement with data. They further posit that such recursive and reflective processes are necessary to generate a richer reading and a fuller understanding of the data to cluster paragraphs and phrases of stories into themes that, for example, convey meaning in peer support and public hospital contexts to bring the whole story to life. Using Delve, I took notes on my transcripts while reading, re-reading, and coding them.

The above data analysis happened through a 3-stage process. The first stage happened after each interview and consisted of 1) having a verbatim automated Zoom transcription of the in-depth interview, 2) placing Zoom audio transcripts in a password-protected Google Drive folder, 3) removing personal Information, 4) reading and cleaning transcripts for accuracy, and 5) conducting a post-interview (if necessary).

The second stage involved 1) re-reading transcripts and 2) writing reflections about major takeaways and themes: peer support, professional meaning, organizational commitment, and supportive work environment.

The third stage was the coding process using delve and included 1) inductively coding when analyzing data, 2) implementing an open, thematic, and axial coding process, 3) dividing codes into main themes and sub-themes, and 4) clustering essential texts or quotations. (see **Appendix G**)

This study used the third data analysis stage to code by carefully examining the themes and reflecting on the participants' stories from a four-dimensional perspective: social-contextual peer support, time, place, and specific nursing occupation. From these perspectives, this study discovered that the aspects of stories shared similar characteristics required for valuable and quality nursing, even though the roles, responsibilities, and peer support experiences differed among military, mental health, and emergency nurses.

Validity of the Study

Scholars of qualitative or narrative inquiry have operationalized "traditional, positivist standards of quality, such as validity and reliability," with credibility (Dodge, Ospina, & Foldy, 2005, p. 295). Credibility in a narrative inquiry is then established by honoring participants' true voices while doing the "back and forthing" (Clandinin & Connelly, 2000, p. 56) and ensuring the findings and conclusions claims are supported by a detailed description of the "unprocessed raw data" (Dodge, Ospina, & Foldy, 2005, p. 295). In this view, sense-making and capturing the meaning conveyed by participants' stories and lived experiences help to establish credibility.

This study uses two validation methods to verify the credibility and trustworthiness of this study's data, as described in Creswell and Miller (2000) and Riessman (2008): verisimilitude

and utility. Credibility is built through verisimilitude when readers believe the research reports are real and relatable (Creswell & Miller, 2000). The utility creates credibility if the study is significant in being accessible, well-interpreted, and clear and can serve as a foundation for future research (Riessman, 2008). This study's raw data or stories are seamlessly linked and detailed to clearly reflect and give life to the stories or lived experiences of mental health, military, and emergency nurses because their narratives enable insights and deepen trauma, support, and empathy in understanding their world. This study also clearly explains its data collection and analysis processes in the hopes that it can serve as a springboard for future public administration research.

Conclusion

This chapter justifies this dissertation's use of Connelly and Clandinin's (2006) narrative framework. This chapter also addresses the importance of purposive sampling in qualitative and narrative inquiry studies. Purposive sampling allows this study to strategically select nurses with specific characteristics, experiences, or perspectives relevant to the research questions and purpose. In that sense, purposive sampling enables this study to target and select mental health, military, and emergency nurses who can provide rich, in-depth insights into nurses' peer support. By selecting participants based on predetermined criteria, such as expertise or unique perspectives, this study can ensure the relevance and depth of the data collected, enhancing the credibility and validity of the study findings.

This chapter also discusses how using Connelly and Clandinin's (2006) narrative setting perspective enhances the credibility and richness of the data. For example, according to Connelly

and Clandinin (2006), the narrative inquiry setting encompasses the contextual and relational elements that shape the storytelling process. This setting is not limited to a physical or virtual location but encompasses the broader context within which narratives are situated, including social, cultural, historical, and organizational factors. Using such a narrative inquiry setting, I engage with this study's participants in meaningful dialogue, creating a safe and supportive storytelling space. The setting influences the types of stories shared, the themes that emerge, and the ways in which narratives are constructed and interpreted.

The following chapter presents the findings, reflecting the types of stories shared and the major themes that emerge. Sharing these findings is critical because it contributes to advancing nursing knowledge by disseminating new insights, trends, and patterns uncovered through the stories of this study's mental health, military, and emergency nurses.

CHAPTER FOUR: FINDINGS

This chapter presents study findings using Connelly and Clandinin's (2006) narrative inquiry framework to reflect seen themes through the peer support components of nursing according to this study's mental health, active duty/reservist military, and emergency nurses. Sharing this study's findings can inform evidence-based practice and policy development in healthcare organizations. Healthcare leaders and policymakers can use the findings to identify areas for improvement, allocate resources more effectively, and implement targeted interventions that enhance peer support and promote nursing well-being. Also, by amplifying this study's nurses' voices and highlighting the significance of peer support in nursing, this study's findings validate the experiences and perspectives of nurses who participated in this study, affirming their voices and contributions to healthcare practice and research. Lastly, this study's findings serve as a catalyst for positive change, driving improvements in patient care, nursing practice, and organizational culture. This chapter is organized to respectively reflect the narratives of mental health, military, and emergency nurses.

Mental Health Nurses' Narratives

I interviewed four female and three male mental health nurses who work in public hospitals: **VT** is a black male from northern Texas; SB is a black female from southeast Texas; GA is a black female from southern Florida; **FM** is a black male from northwest Georgia; **AB** is a black female from southern California; and **DT,** a black male, and **ZW,** a white female, who are both from Washington, DC. Most of them wanted to be nurses when they were younger. **AB**,

a female with 3 to 6 years of mental health nursing experience, says, “I have always wanted to be a nurse because I felt like the world could use a little bit of kindness and help, and we just gotta help each other because not everybody is as strong as some of us...that got me started on this journey.” Like many SLBs, mental health nurses are motivated by a sense of duty to help people (Rauhaus, 2022). Many mental health nurses in this study chose their educational paths to be at the frontline of mental health because they had the purpose of helping individuals deal with mental health challenges. In addition, others entered the mental health career because they saw the field as overlooked and rife with stigma. **FM**, a male with 3 to 6 years of mental health nursing experience, joined the mental health field to empower and advocate their work because he cared and “found out that mental health is actually quite overlooked. Most people see mental health as something for the weak.” In other words, caring is a concept that allows mental health nurses to assist their clients in developing a sense of self, avoiding stigma, and facilitating the road to recovery (Warelow & Edward, 2007).

Caring for this career and highlighting how mental health nursing differs from other types of nursing, these nurses feel they do more than care for a general adult population or treat patients with physical health difficulties. For example, besides the extra experience or training in mental health nursing or becoming board-certified psychiatric mental health nurses, “mental health nurses have different responsibilities compared to maybe someone who works in an emergency, because they deal with patients with rage, depression, bipolar disorder, schizophrenia,” and emotional fatigue said **DT,** a male with 2 to 4 years of mental health nursing experience. Furthermore, mental health nursing is “a very passionate job because it is not like your daily nurses you might see at the hospital. We do more than just tending to physical injuries here; we turn to the mind,” added **AB.** This component of mental health nursing, the mental

health nurses in this study mention, is crucial to how they view patients and help them recover by connecting and evaluating their mental health needs**.**

The stories of mental health nurses in this study reflect that they work in diverse settings and teams. For example, many of the mental health nurses in this study serve different populations, such as people with depression, mental disabilities, and children, and collaborate with a variety of mental health professionals, such as psychologists and social workers. **ZW**, a female who has been a mental health pediatric nurse for 3 to 6 years, explained, "I am a part of what we call our psycho-social support group. So, I am the designated trauma burden nurse. However, I work very closely with a clinical psychologist, a social worker, a trauma nurse practitioner, a child life specialist, and an occupational therapist, all to support not only the physical rehabilitation of these kids but addressing the trauma and the mental health that comes with it, not only for them but for their parents too."

The mental health nurses interviewed for this study are passionate about their jobs. For example, **VT**, a mental health nurse with 3 to 6 years' experience, stated that mental health nursing "is now like something I love. It is part of my life, and I am continuing to do it wholeheartedly more and more to save lives." Given that this is a self-selected sample, one may anticipate those who volunteered to be particularly passionate about public service. Public service provides a platform for mental health nurses to use their skills to create meaningful actions such as saving lives. With a passion for public service, the mental health nurses in this study describe the impact of peer support - preceptorship or mentorship - on their stressful job in two themes: professional meaning and organizational commitment.

Theme of Professional Meaning

Formal or preceptorship and informal or mentorship peer support is an interpersonal, relational, and social process that allows mental health nurses to acquire professional meaning. Preceptorship and mentorship are interpersonal, relational, and social processes that play a pivotal role in fostering the acquisition of professional meaning among mental health nurses. Through these supportive relationships, new nurses are guided and supported by experienced mentors or preceptors who provide valuable insights, guidance, and encouragement as they navigate the complexities of mental health nursing practice. The interpersonal dynamics inherent in preceptorship and mentorship enable mentees to develop a sense of belonging, motivation, autonomy, connection, and professional purpose, fostering a supportive and collaborative learning environment. This collaborative learning environment process leads to reflective dialogue, collaborative problem-solving, and shared clinical decision-making in mental health nursing. This process facilitates the transmission of tacit knowledge, values, and professional norms essential for mental health nurses to develop professional identity, cultivate a deeper understanding of their role, and enhance their sense of professional fulfillment and meaning. Consequently, in this study's mental health nurses' narratives, the professional theme has six sub-themes that help them reach professional meaning. They are Personal/Professional Identity, Motivation, Peer support in mental Health, Professional Purpose, autonomy, and sense of belonging.

1. <u>Sub-Theme: Personal/Professional Identity</u>

"*I do this job because I needed this kind of help when I was younger, it just pushed me towards this kind of job*."

In their stories, the mental health nurses in this study describe that they gain professional meaning within the interplay between their personal struggle, purpose, identity, and professional identity formation in mental health nursing. The following passage captures how **AB** perceives the intersection between her needs as a young person and her willingness to be a mental health nurse by stating that "people just go about being strong and all, but deep down they just need a little bit of care if you ask how they really are. I think this prompted me to do this job because I needed this kind of help when I was younger; it just pushed me towards this kind of job." However, personal aspirations and even going to school to be a mental health nurse are just the beginning of this role. After graduation, the interviewed mental health nurses report they need a preceptorship or mentorship program because it equips them with more practical expertise to handle clinical setting challenges. **GA**, a female with 1 to 2 years of mental health nursing, describes her experience:

> You are just fresh out of college. You notice that what we learn in school is somehow different from the real work in hospitals. So, at least, someone needs to be there to show you how things work in the field and how we can deal with patients.

Given **GA**'s statement and the rising need for a skilled nursing workforce, practical experience is crucial for nurses' work readiness. For example, Rebeiro et al. (2015) synthesize the literature on interpersonal relationships between nurses using articles published between 1990 and 2013. They find that nurses' work readiness or development of essential nursing skills

extends beyond classroom training and depends on the quality of preceptorship or mentorship. Moreover, establishing a productive preceptee or mentee and preceptor or mentor interpersonal relationship optimizes new nurses' work readiness through clinical and practical instructions (Edward et al., 2017). Race and Skees (2010) draw on their decade of critical care nursing experiences and mentoring literature to argue that the practical skills and support received through mentoring are crucial for new nurses to become less stressed, stay in nursing, and succeed. What **GA**'s statement shows is that mental health nurses do not learn everything in the classroom, and practical real-world skills gained via preceptorship or mentoring are required to help mental health nurses gain the skills they need to do their jobs.

In this study's interviews with mental health nurses, the conversation about the gap between the classroom and real-life mental health nursing also turned to the necessity of experiencing formal and informal peer support. In their stories, each participant narrates about peer support as a catalyst for escaping the most challenging first years of the profession. **AB** explains:

> When I first started at my hospital, we had a formal and informal kind of mentorship because getting into this field could be a bit daunting for some. Sometimes, you see people giving up after a few weeks. Oh, I can't do this because of my mental health. And you find a lot of young nurses living to go do easier jobs. So, we had formal and informal mentors. The formal ones were assigned to us at the start. We had to do every job literally with these people guiding us and letting us know we got this, we could do this. That helped a lot for about a month and a half. After that, we were allowed to work by ourselves. This helped a lot because, even if there were some things

> we didn't know or were not able to handle being a nurse for the first time, seeing them treat people with so much love, patience, and kindness, regardless of how long it took. And watching these people and helping them feels like the highlight of it all.

AB's quote exemplifies why peer support or informal and formal training such as preceptorship and mentorship is a crucial developmental, supportive, and retention tool for new nurses. In fact, recent policy implementation studies show how such engagement or training between peers not only increases SLBs' capabilities to do their work effectively but also allows them to self-identify and adopt collaborative approaches to delivering services (Buffat, Hupe & Hill, 2015; May & Winter, 2007). According to **AB**'s quote, a practical mental health nurse's growth approach combines preceptorship, mentorship, and a supportive and collaborative peer environment. **AB**'s quote then emphasizes the importance of mental health nurses recognizing that peers play an important role in building their professional identity, which influences their care delivery process. **SB**, a female with 4 to 8 years of mental health nursing experience, also added:

> I think both formal and informal mentorship helped to build me. What I learned from it is that we are not perfect, but we can help each other to be perfect or grow towards perfection. Nurses would have completed their license, maybe their needed practice hours and everything that is needed, but they can never be perfect. But through mentorship, we can help to grow towards being perfect. The mentorship has really affected my career and my professionalism positively because I have learned more skills that I did not know from it. During the mentorship, I also listened to other people about what worked for

> them or did not work for them. I have shared my experiences, and I think it helps us to look at things for what can work and what doesn't work.

SB's positive reinforcement of the utility of formal and informal peer support above focuses on gaining insights into how peers manage stress and maintain well-being, as well as idolizing mentors who skillfully navigate difficult clinical situations, which assists mental health nurses in developing their own resilience skills. That is, SLBs make judgments in a clinical context as part of a team based on a set of tacit practices, and mentees idolize mentors' exemplary work in order to become the professional mental health nurses they aspire to be and care for patients (Rutz et al., 2017). **SB**'s statement about growing towards perfection demonstrates how mentees see mentors as outstanding sources of practical knowledge and role models. Similarly, in the mentoring literature, mentees regard mentors as role models because they feel they exhibit behavioral or professional attributes that should be imitated (Pleiss & Feldhusen, 1995). **FM** describes this imitation process:

> I am gonna tell you a little bit of a story here. There was a patient. I think she was with us for about three months. About the first four weeks, it seemed like we were not really making any progress with her. She was quite adamant and did not really listen to our instructions. But then the senior nurse was very, very patient. If the patient refuses to carry out some activities, she just comes back tirelessly and patiently the next time. She is not gonna get mad at you. She is just gonna try and explain all over again why we need to do this. We have to get you through this hurdle for you to be better as a whole - for you to be better for the community and your children. So, she kept on explaining over and over and over again, and then in my mind, I was like, Oh, wow! She is quite patient because I

> did not think I would have exercised that much patience with the lady. And then it turned out nice because she eventually got it okay. So, this nurse, as my mentor, had a really positive impact on me. I mean, you see, this nurse takes care of a lot of patients so perfectly and properly. She talks to them whenever they need to and is there for them all the time. And I am just like, wow, this person is amazing. I want to be like this; I want to be better than this person. So yeah, it really had a positive impact on me as a nurse.

FM's quote illustrates how he regards his mentor as a role model, focusing on the mentor's patience. **FM** believes that mental health nursing requires an unusual degree of patience since effective care delivery is dependent on patience. Mentorship in mental health, as described by **FM**, fosters natural learning, aspiration, and empowerment to provide high-quality public service. It is a social interaction for individuals seeking to advance their careers. Shim et al. (2021) and Taylor (2013) argue that SLBs who feel empowered when they observe the positive effects of their work are motivated and energized to provide high-quality public service and are committed to their profession. Mental health nurses are energized and committed to their profession because of the positive impact their mentor have on their professional identity.

2. <u>Sub-Theme: Motivation</u>

"What happens after the mentorship is that you will feel re-energized."

Another prominent theme in interviews is motivation. Many mental health nurses in this study agree that when adequately trained and mentored, they are motivated to apply their new skills to offer essential mental health assessments to patients. As **SB** puts it, "what happens after

the mentorship is that you will feel re-energized. You have gained new skills again, and you just wanna try them out on patients with that load of energy. So that is how it has really given me more motivation to help my patients."

SB's comment exemplifies the value of mentorship in motivating mental health nurses to do their jobs. Such motivation in the mental health field creates the basis for believing in oneself and feeling that one possesses the necessary skills to care for any patient, no matter how challenging. **AB** recalls a problematic patient with mental health issues that made her doubt her abilities at first whether she could help him. However, reflecting on her mentorship, she states, "I was able not just to help him, I was able to make him a lot better than when he came in, and that felt really good. I felt so proud of myself. I felt so proud of the job I was doing, and I was happy. I had people who helped me feel like I could do things by myself." According to AB, mentoring support gave her confidence in herself and her skills, motivated her to not give up on the patient, and strengthened her professional identity and meaning.

Mentoring support in public mental health hospitals not only reinforces professional identity and meaning but also the intrinsic motivation of the task of helping patients, which is often rewarding in and of itself (Norton, 2018). **SB** explains further that this intrinsic motivation boosted her confidence in herself and her skills and made her feel competent in engaging in more complex mental health situations to be productive in her hospital. She notes that "mentorship is really important and necessary. And it can help to improve someone's productivity. So, it is mentorship that can increase the efficiency and productivity of any nurse." **SB**'s statement outlines how mentorship support can intrinsically motivate mental health nurses, resulting in increased performance and improved job outcomes. This statement aligns with Deci and Ryan (2009) and Norton (2018), who maintain that intrinsic drivers such as skill mastery, purpose (the

commitment to one's professional goal), and relatedness (peer support and sense of belonging) not only help maintain motivationally optimal states that meet basic psychological needs but also improve output productivity. Mentorship enables mental health nurses to feel more confident in their abilities and to be motivated at work.

3. Sub-Theme: Peer Support in Mental Health

"*I think it is just the perfect example of peer support because these are practitioners that I have never met before. I may not meet them ever again, but we just have this super significant moment together.*"

According to the mental health nurses who participated in this study, both mentoring or informal peer support and preceptorship or formal peer support are useful in supporting nurses to stay motivated and productive at work. They further clarify that peer support may be more than just formal or informal training or a verbal relationship; it can also be a practical and clinical skill exchange. This clinical exchange is crucial in providing adequate care and saving patients' lives since nurses do not need to know each other to care for a patient jointly. This is demonstrated in **ZW**'s story:

> We just admitted a patient. I was not the patient's bedside primary nurse, but another nurse admitted him, a 15-year-old boy who had a one-time seizure and no other medical issues. The medical team decided to admit him overnight. They put all those electrodes on his head, tested his brain waves in EEG, and just kind of kept an eye on him. Everything seemed to be going perfectly normal. He was walking and talking and kind of

annoyed to be in the hospital. Then, his mom decided to head home to pack a bag of overnight stuff. His mom had probably been gone for about 20 min, and then all of a sudden, this child just kind of collapsed, and his cardiorespiratory motor that shows us his heart rate, his respiration rate, his pulse symmetry, all that started just going off. My manager, who was in her office right next to this patient's room, heard the alarm and rushed in, suspecting something was wrong. I am not sure how many years she has been a nurse, but she has been one for a long time. She has worked in ICUs and our unit forever. She is very knowledgeable. She was assessing the patient when another care provider and patient technician stopped by to help. Somebody ended up pressing the code blue button, which sends a hospital-wide alert that a serious respiratory cardiac event is happening. This prompted members of our ICU and emergency department teams to all come to the room to figure out what was going on. So, this was around 2 pm. The bedside nurse for this patient was, I think, a new graduate who was only 2 or 3 months out of orientation, so she was very new. Our neurology team was taking care of this particular child. So, it is not even our floor specialty. We had an open bed, and they used it. We have worked with neurology kids before. It is just not typical, but the nurses were running over, and suddenly, there were 10 to 15 people in the room. I was just walking down the hall when I heard the alarm and ran in. I have been a nurse for probably five or so years. I was on our leadership team, so pretty settled. I, at any time, like an alarm that starts to go off, I tend to go to them. That is just how I work best. I immediately saw that they were setting up for a Code situation... and all of a sudden, we started doing progressions, something I had never done before. Our floor was acute care, not intensive care. So, when children were in that realm of degree of injury or illness, they would typically go to the ICU. We

obviously are trained to do CPR and those life-saving measures, but this is the first time we actually had to use them. The whole process took about 45 min. We were doing CPR and ended up calling the time of death on the patient. And it was just super random. Nobody knew what happened. But what stood out to me in terms of peer support was just the level to which everybody just kind of dropped what they were doing, and without a word, just seamlessly fell into these different roles… And it is kind of like a choreographed dance in a way where, in such a moment of chaos, everyone ultimately knows what is most important and what people really need to just focus on and do so. We didn't need one single leader delegating. It is just people, without question, jumping in, and this new nurse was super shaken up by it. And it was nice to be able to sit aside. At that point, she couldn't really participate in the Code. She was a historian, telling us what had happened, but she wasn't there at the time he collapsed. She obviously had known this patient for probably 20 min at the time. And so, once she was able to do her part of expressing the history, somebody else was able to take her into a separate office like, give her an orange, do some crackers like, let her just kind of sit and take a breath. And some of the people who were able to run the Code when the patient ultimately passed away had to stay behind to do postmortem care, which isn't something that is common on our unit; I have never done it before…And we will process emotions after every Code. There is a debrief where everybody who is involved sits together and speaks for however long they need to, from ICU doctors to the respiratory therapists. And that just provides a lot of closure for these sorts of events. And I think it is just the perfect example of peer support because these are practitioners that I have never met before. I may not meet them ever again, but we just have this super significant moment together.

ZW's story about the young boy is both heartbreaking and illuminating. It is unfortunate that they were unable to save him. However, it is important to see how the support system is established in the event of an emergency. **ZW** describes a support system of trained healthcare workers with various titles and expertise who worked together effortlessly to try to save the patient's life. Such a system is based on technicality, autonomy, and emotion. Peers, for example, supported the new nurse who admitted the patient or supported one another at a debriefing to reaffirm the genuine meaning of care, teamwork, and support. Furthermore, as illustrated by **ZW**'s story and evidenced by research, nurses support each other vocally or technically during complex clinical events to establish teamwork and satisfy their psychological needs, enhancing bureaucratic efficiency and a sense of purpose as nurses (Tamer & Dereli, 2014). Mental health nurses gain a feeling of purpose because they believe they are part of efficient systems that support peers and benefit patients.

4. Sub-Theme: Professional Purpose

"*I always knew I wanted to be a nurse but this kind of strengthened that. Just knowing I could have a direct impact on their lives and just change their lives around for the better, I feel that is a great thing to do*."

In this study's interviews with mental health nurses, discovering meaning in the mental health profession is closely tied to recognizing one's professional identity. The mental health nurses interviewed further clarify that professional identity, together with a peer-supportive

working environment, lead to professional purpose. **AB** explains below how peer support fostered a helpful workplace environment that increased her professional purpose.

> Sometimes, we feel like we can do things that are above us, or they are bigger than us, or they are beyond our field. But we just need motivation from people who really know us and are rooting for us, and this could go a long way to push you and to motivate you to make you do even greater things than you thought you could. I feel like I have that. My peers at the time were a big boost to my personality and my job in general because right now, I go to work with a mindset that I can do anything; I can do whatever I set my mind to. And I feel everybody needs that. Everybody needs that one person at work who is always pushing you to do greater things. I always knew I wanted to be a nurse but this kind of strengthened that. Just knowing I could have a direct impact on their lives and just change their lives around for the better, I feel that is a great thing to do.

AB's quote emphasizes the value of peer support in developing self-efficacy, autonomy, optimism, and a feeling of purpose. Such peer support, reflected by **AB**, is provided by emotionally mature peers who are experienced enough to assist new nurses in attaining their full potential and feeling great about their job. In reality, peer support provided by emotionally mature and experienced colleagues is an evidence-based practice that develops and enhances professional commitment, self-efficacy, and autonomy (Godfrey & Scott, 2021). Mental health nurses view peer support as a useful strategy experienced peers use to reinforce the professional purpose of newer mental health nurses by learning the skills and autonomy to enhance patients' mental wellness.

5. Sub-Theme: Autonomy

"Moments, when we came together to try to save that boy, were when I felt like I had the most autonomy."

According to the mental health nurses who participated in this study, autonomy refers to the freedom to simply do the job they signed up for or the ability to make clinically sound decisions in life-or-death clinical situations. For example, **ZW** operationalizes below autonomy as the freedom to just do her work:

> Moments, when we came together to try to save that boy, were when I felt like I had the most autonomy. There are a lot of problems with the healthcare profession in all sorts of ways. And it is a profession I very much struggle with in terms of having a large amount of frustration with the way healthcare is run and the way I am able to do my job. But at the heart of it, when you have these literally life or death situations, you are able to take the skills you have which are so specialized, and you are able to rise to the occasion and do things in a way that's like this is health care. This is what we are trained for, and this is what we are able to do. We have this incredible technology at our disposal, this incredible training, and we are not being slowed down by the focus of like customer service, which is now a huge part of healthcare. We are able to just really focus on what needs to be focused on and do the work.

ZW's comment above demonstrates how peer support enables mental health nurses to utilize clinical contexts to have the autonomy to use their expertise to save people's lives while not being slowed down by aspects that regulate healthcare, such as customer service. **ZW**'s experiences are consistent and reflective of research findings. For example, autonomy in mental health public hospitals, as in several SLBs' research, is generally constrained by rules, practices, and laws that define the context of their work but not by their judgmental actions and pragmatic improvisations when practicing their skills or performing their duties to save patients in critical situations (Maynard-Moody & Musheno, 2000). As a result, saving patients for mental health nurses is about more than just providing superficial customer service; it is about working together to facilitate processes and establish a sense of belonging for everyone.

6. Sub-Theme: Professional Sense of Belonging

"You are just like it is our little world. No one else is clued in. You are kind of isolated in it."

Another prevalent theme in interviews is a professional sense of belonging. This study's mental health nurses believe that a professional sense of belonging is essential in recognizing the value of peer support and finding meaning in mental health nursing. Many mental health nurses, in their stories, find it beneficial to interact with their peers when they are sharing trauma that defines their world and that outsiders cannot understand. In this sense, they feel they belong to their own small world, as **ZW** describes below:

> People throw around the term trauma bonding a lot. If you are in the trenches together, you get a lot closer, and that is something I have absolutely appreciated through working

> in healthcare, especially during COVID, like you are together. You are facing this literally crazy stuff. I will come home, or I will talk with outside-of-healthcare friends, and they are like jaws on the floor. That was your day. It is just a Tuesday, and this is insane. But to me, it is just another day. I will have to do it again the next day and the next day. And you build such deep relationships with peers because they get you. You don't have to worry about editing your stories from work. I will have a couple of stories that I wanna tell people that are truly disturbing, and they involve, like, child abuse and all that kind of stuff. But at some point, I need to talk about it to take care of myself. But my friend, who doesn't like violent movies, can't hear about it because she doesn't want to, and I respect that. So, I don't. But my peers are the people I can talk to about that, and there's nothing quite like it, especially when you are working these odd hours, these holiday shifts at 3 am, and you are just like it is our little world. No one else is clued in. You are kind of isolated in it.

ZW's quote describes how peer support enables mental health nurses to bond over traumatic clinical situations or pandemics such as the COVID-19 pandemic. She notes that mental health nurses provide opportunities for peers to vent about traumatic and challenging situations, giving them the impression that they can bond and share these experiences with just their peers to preserve their mental health and well-being. Moreover, nothing is more traumatic for frontline healthcare professionals than the COVID-19 pandemic. COVID-19 caused much anxiety, especially among mental health nurses who could not go home and needed to stay in the thick of it all to support their patients. COVID-19 also bonded mental health nurses into a family through the shared clinical trauma they experienced. **AB** explains:

> At that time, we were very reliant on each other because COVID was a big blow on every single person, even I would say most especially for healthcare workers because we couldn't go on break like others and couldn't stay back at home like others. We still had to show up at work. We were showing up with the mindset that anything could happen, like we could get infected. At the same time, having my peers around me felt like I had my family. It gave me strength, and we kept going with the belief that we would see the end of this together.

AB's statement explains how the COVID-19 pandemic increased many SLBs' duties, such as nurses, increasing their stress and deteriorating their well-being. Her statement also reflects how COVID-19 was a significant hit to mental health nurses' morale and an essential method for them to unite as a family. Such a union, she says, enabled them to do things they never imagined possible, survive situations like COVID-19, and increase the level of peer support to promote social belonging. Research supports **AB**'s account. For example, Linos, Ruffini, and Wilcoxen (2021) conducted a multicity randomized control trial with 536 911 dispatchers in nine mid-sized cities and a parallel online experiment with 497 more to show that workplace-based interventions that increase perceived social support among peers can reduce burnout and turnover. They argue that social belonging reduces SLBs' burnout by encouraging them to seek peer support, protects and improves their well-being in the face of uncertainty, and fosters commitment to their job and peers. Social belonging or a sense of belonging is critical for mental health nurses since it improves their well-being, teamwork, communication, and collaboration while positively affecting patient care and organizational outcomes.

Theme of Organizational Commitment

Organizational commitment refers to the level of engagement and commitment to one profession and organization. Even though the majority of mental health nurses are grateful to their organizations for giving them a job as well as formal peer support or preceptorship and informal peer support or mentorship training opportunities to enhance their skills and careers, they do not "marry [an organization] logo or name." Their commitment to their profession extends beyond organizational affiliations or logos. Their professional commitment is rooted in their passion to provide compassionate care to mental health patients while prioritizing their well-being and recovery. Moreover, their commitment to their peers is evident in their collaborative approach to care, where they actively engage in interdisciplinary teamwork, knowledge sharing, and mutual support to address the complex needs of their patients. While mental health nurses may value their organizational roles and responsibilities, their commitment is inherently tied to their professional identity and the collective mission of promoting mental health and wellness in their communities. As a result, two sub-themes surfaced with the organizational commitment theme: professional commitment and peer commitment.

1. Sub-Theme: Professional Commitment

"I am not at my job because I love the organization. I am at my job because I love the children I care for and my co-workers."

In this study's interviews with mental health nurses, mental health nurses express that they build professional commitment as they form bonds from shared clinical trauma experiences, supporting each other and becoming family. According to them, professional commitment is the

foundation of professional meaning and commitment since it entails dedication to the nursing profession, readiness to embrace mental health nursing norms, and making significant sacrifices for the profession. **ZW** gracefully explains why she continues to do her job:

> I am not at my job because I love the organization. I am at my job because I love the children I care for and my co-workers. There are some things about the organization itself that I'm frankly not happy with and that I would change in a heartbeat. Unfortunately, problems probably exist in every healthcare organization. So, I'm not married to a logo, a brand, or a name. It is just about the literary work that I do.

ZW's statement above exemplifies how peer support fosters a specific form of care and affection among mental health nurses. Peer care, according to **ZW**, allows mental health nurses to enjoy their work, support their peers, and care for their patients more. ZW further emphasizes that mental nurses stay at their jobs because they care about their peers and patients, not the organization. **ZW**'s statement is consistent with Maynard-Moody and Musheno's (2022) research, which shows that SLBs' work is based on self-sacrifice for their citizen clients and inhabited institutional accountability to peers. Mental health nurses show commitment to their profession by caring about their peers and patients.

2. Sub-Theme: Peer Commitment

"I feel like I could easily walk away from the entire healthcare system…if it wasn't for my coworkers."

According to the mental health nurses who participated in this study, peer commitment in the mental health field reflects interpersonal, social, and emotional elements among peers. These elements make mental health nurses want to stay at their jobs. **ZW** reflects:

> I feel like I could easily walk away from the entire healthcare system, hospital setting, and everything else if it wasn't for my coworkers, who gave me the passion, energy, and ability to actually take care of patients. These are the people that make me emotionally tied to it and intrinsically motivated to keep coming back to work.

ZW describes above how her peers and their support provide her with the energy, ambition, and enthusiasm she needs to return to work every day and gladly care for her patients. **ZW**'s description is supported by the peer support literature. Peer support, mainly in the nursing field, is regarded as a critical motivator for nurses to stay at their jobs due to the friendliness of peers and their support (Hayhurst, Saylor & Stuenkel, 2005). Peers' friendliness and support motivate mental health nurses.

Furthermore, in their stories, mental health nurses believe peer commitment is recognizing the support of your peers when you most need it. **FM** clarifies his commitment to his peers:

> Well, they really helped me. They came through for me when I really needed help and when it felt like nobody was paying attention to me. So, I am really committed to them. I actively want to try and get the best out of everybody who works with me because they

> have really, really been a good help to me. So yeah, I am committed to giving back to my peers.

FM's comment above suggests that when peers support him during a critical time, it is natural for him to be committed to reciprocating as much as possible. In this study's interviews, mental health nurses further explain that peer commitment is a cyclical process of accountability because they feel not only accountable for preventing new nurses from experiencing the stress and fear they did at the start of their careers but they also feel like they are giving back to the nursing profession by ensuring newer nurses have the necessary skills to be competent at their jobs and deliver quality services. **AB** mentions that:

> Right now, I look after new nurses. And it feels great being a source of motivation to others who look up to you to do a good job. It has been great. I feel like I am really committed to them because, in the end, they are not just colleagues anymore. Most of them are like family. And we really, really have this bond we share to come to each other's rescue as much as we can. And it is great. Most of them are ladies, and we visit each other. We even help with babysitting and all that. So yeah, it is not only professional; it is even outside the workplace.

AB highlights above how peer support may have professional and unprofessional (outside of work) characteristics in persuading peers to commit to professionally developing peers while also personally supporting them in achieving a better work-life balance since they are a family. Also, **AB**'s sentiment of giving back or feeling accountable for other nurses is supported by the

SLB literature. As demonstrated in previous SLB research, healthcare practitioners' professional accountability has intra- and inter-components while being accountable for their actions and peers (Hupe & Hill, 2007). Mental health nurses demonstrate commitment to peer development because they feel accountable for peers' actions in effectively facilitating patients' recovery journey and improving their quality of life.

Military Nurses' Narratives

I interviewed seven female military nurses, serving either on active duty or reserve (see **Table 4** below): **MM** is a multiracial female located in eastern North Carolina; **PT** is a white female in northeastern Illinois; **JD** is a white female in Washington, DC; **OB** is a black female, and **CV** is a white female in southern and eastern Florida; **DM** is a white female in western Pennsylvania, and **HW** is a black female in western Pennsylvania. Many of this study's military nurses aspired to be nurses because they were passionate about caring for others and being there for them, particularly during difficult times. Also, because these nurses took the nursing oath to pledge to save lives ethically, they want to be there for patients during their lows and celebrate them on their highs. **DM,** a medical-surgical nurse, and reservist with 10 to 34 years of service, exemplifies such behavior below:

> I think it is just that oath that we took after graduation or before graduation and knowing the value of life for human life. If this person can benefit from even one thing I can help them with, why would I not do that? Why would I withhold that? Just because I am

> having a bad day. No, no, no, no, it is all about them. That is why you go into healthcare or nursing. Anyway, if that is not where your heart is, then you shouldn't be a nurse. Every life is valuable, and they deserve all you can offer them, and forget about yourself. So, you just have to remember that oath that you took as a nurse and the value of human life.

Military nurses, as described by **DM**, prioritize their patients' needs, even if it means going through uncomfortable processes to value and save their lives. This patient prioritization is congruent with SBL literature, as risking everything for their citizen clients is a major component of being an SLB (Maynard-Moody & Musheno, 2022). Military nurses sacrifice themselves for their patient's well-being.

Recognizing the value of human life to save lives is vital for these nurses, but so is serving their country and saving the lives of their brothers and sisters in uniform. "I like serving my country. I like being able to care for my brothers and sisters in uniform," says **JD**, an active-duty Navy critical care nurse with 10 to 24 years of experience. This expression of patriotism and care for other military members is further mentioned by **HW**, an army active-duty critical nurse with 3 to 6 years of experience, when she says, "it is my passion in saving lives and also caring for the service members of our country."

JD and **HW** both describe a degree of patriotism, public service, and care that guides military nursing. The patriotism and care for fellow military personnel exhibited by **JD** and **HW** are consistent with public service motivation literature. In terms of public service motivation, military nurses' patriotism, or desire to serve their country, as described in their stories, is more than only seeking psychological needs, as mental health nurses are. Their public

service motivation combines sociological and organizational institutionalism attributes with a focus on serving the interest of the public (Taylor, 2008). According to the military nurses in this study, sociological attributes emerge through their social identity, motives, and attitudes. They further explain that their organizational institutionalism attributes reflect their values and norms. The concept of social identity and organizational norms for military nurses in this study bridges the gap between sense-making about aligning family identity with professional identity to contribute to positive social change. For example, many military nurses interviewed for this study felt naturally compelled to join the military since it is a family tradition that provides them meaning and purpose. **MM**, an army reservist, and medical-surgical nurse with 4 to 8 years of service, for example, notes that:

> I come from a military family. So, the military is kind of a tradition for me, but it just kind of gives me a bigger sense of purpose. So, not only am I caring for people in general, but I am also caring for people who have chosen to kind of put their own personal wants on the back burner and serve like this bigger picture. It has always been a privilege to do all these things for people. And the adventure of traveling, meeting different people, and seeing other cultures is something that I really wanted to do.

MM recounts how joining the military as a nurse gave her a sense of identity and purpose. She believes that serving frontline military members and the general public allowed her to travel, learn about many cultures, and become a well-rounded individual. In this study's interviews, military nurses recognize that the feeling of adventure not only motivated them to join the military but it also set them apart from other nurses. Military nursing entails travel to different

nations and knowing different cultures, as well as anticipated deployment to combat zones and specific training. For example, “in the Navy, your responsibilities as a nurse don’t just include being a nurse. They also include being an officer and a military member that have multiple different hats and responsibilities.” **JD** explains. Being an officer first differentiates these nurses from civilian nurses because of the type of training and role they play. **MM** notes, “we do a lot of field training that is supposed to prepare us if we are ever deployed. So, we do a lot of trauma courses and emergency medicine, such as field medicine. So even if you are a medical-surgical nurse in the civilian world, you wouldn’t typically see this type of training.” Furthermore, everything is organized in military nursing. They participate in field exercises in preparation for deployment, attend a mandatory 5-week direct commission officer and induction course, occasionally travel to conflict zones, have a different population, and receive training that civilians do not receive, all of which give them a very different clinical competency. **JD** explains:

> Theoretically, our patient population is healthy, and most of the time, when we see trauma, it is at war. So, if our country is not at war, we do not see as much trauma. Then, our training opportunities can be different in the military. In my time, I have tried to do things that I am only able to do in the military because where else am I going to get the opportunity to do those things? And most of my career has been at war. So, I have a lot of that experience as well.

JD explains that she acquired many critical nursing skills that a nurse can only acquire in the military setting or treating trauma patients in war zones. She also mentions that they have a

very healthy patient population without war. Military nurses who participated in this study have diverse clinical skills and deployment training or experiences that highlight the impact of peer support - preceptorship or mentorship - on their job in two themes: professional meaning and organizational commitment.

Table 4: Military Nurses' Active Duty and Reserve Statuses and Specialties

Participant Anonymized Initials	Military Status	Nursing Specialty
HW	Active duty	Critical care nurse
PT	Active duty	Critical care nurse
JD	Active duty	Critical care nurse
OB	Reserve	Community health nurse
DM	Reserve	Medical-surgical nurse
CV	Reserve	Medical-surgical nurse
MM	Reserve	Medical-surgical nurse

Theme of Professional Meaning

Peer support, both formal or preceptorship and informal or mentorship, enables military nurses to gain competence, leadership, and professional meaning. By observing and learning from their preceptors and mentors, military nurses gain practical skills, clinical proficiency, and confidence in delivering high-quality care to service members. Such proficiency and confidence enhance their competence and readiness to fulfill their roles within the military healthcare system. Also, preceptorship and mentorship programs in the military context foster the development of leadership skills in military nurses, preparing them to assume leadership roles

and responsibilities within their units and healthcare teams. Preceptors and mentors play a crucial role in nurturing the leadership potential of military nurses, encouraging them to take the initiative, demonstrate accountability, and advocate for the needs of their patients and peers. Accordingly, five sub-themes emerged from the professional meaning theme in the military nurses' narratives in this study. They are peer support in the military, emotional regulation, mastery, leadership, and a sense of belonging.

1. Sub-Theme: Peer Support in the Military

"Having your team or people that bring you back to life makes you wonder why you are doing, like, what is the mission? What is the purpose? What are you getting out of this? What is serving your soul?... impacts me and motivates me."

According to the military nurses who participated in this study, they all participated in formal or informal peer support programs at the beginning of their careers. Many also engaged in formal and informal peer support and differentiated between preceptorship and mentorship. **MM**, mentions:

> The formal preceptorship was like I knew that somebody was going to be checking up on me and guiding me, making sure that I was doing the right things and doing it the right, safest, and best way possible for the patient. Unlike the informal mentorship, which was more of a resource that I could use, it was kind of my sole responsibility to make sure that I was checking all my boxes, making sure I was doing the right things.

MM discusses the distinction between preceptorship and mentoring, including the preceptor's check-in process, the mentor as a resource, and her own responsibility to ensure that she exercises her new skills effectively. Furthermore, military nurses describe in their interviews that peer support as a preceptorship in the military can be as predictable and structured as bureaucracy. This structure is important, they believe, because it allows military nurses to maintain a specific level of work quality that reflects the military mission and their commitment to serve the country. **DM** explains the preceptorship process:

> The preceptorship was tremendous in the military, and it is quite structured. The Army Corps did have a specific way of preceptorship: if you are right out of school, here is what you must go through. And even if you are coming from another duty location, it is just a change of assignments, really. There is a check-off list. There are things you have to do, whereas, on the civilian side, they want you to be able to get going and go through the check-off really quickly. And yeah, you are on your own.

DM indicates above that preceptorship in the military is linear and systematic, allowing for the transfer of vital skills. According to her, the military preceptorship processes allow military nurses to improve their skills and competencies more than the civilian preceptorship, which offers less support and is rushed. **DM**'s opinion on a structured military preceptorship is consistent with the literature. For example, bureaucratic organizations are formed to provide a formal peer support structure with a strict check-off list to ensure technical superiority and predictability in administrative behavior and performance (Weber, 1978). In fact, according to

the stories of this study's military nurses, the rigorousness of these formal peer support programs shapes not only the professional identity of these nurses but also sets them up for a successful career. **JD** mentions:

> I think I am who I am because of that preceptorship experience. I think I am at a baseline, goal-oriented, motivated, and like to challenge myself fundamentally. But, I think because of that experience, both clinically from the patients that we were seeing, but also the support and encouragement that I got from my preceptors, and it wasn't necessarily handholding, but it was like priming me with questions, and so I would have to go home and study and look things up. It was very difficult, but it made me work harder and understand that this stuff doesn't just come to you; you have to learn it, and you have to put in the effort. And so, I think because of those experiences, being pushed by my preceptors, and having a higher level of expectation for my performance and competence, I became who I am today. I'm successful.

JD argues that preceptorship in the military is rigid and difficult, but it is made possible by preceptor support and a commitment to strive for one's talents. This experience, she suggests, adds a dimension to her goal-oriented nature, providing her with a professional identity that has led to her current success in her career. Also, as reflected by **JD**, frontline military nurses have specialized skill sets developed through standardized training, leading to professional success and improved professional judgment abilities (Zhang et al., 2022). These abilities help military nurses to make more informed professional decisions regarding their patient's needs in a larger organizational, international, and collaborative context. For example, a

successful military nursing career requires perseverance, expertise, camaraderie, and teamwork to work efficiently, especially during deployment. **PT,** a critical care nurse with 6 to 12 years of experience, reflects on one of her experiences during deployment:

> When you are on deployment, you get to the point. Ok, there is this meme out there that I saw, like the beginning of the deployment. You show up. And you are like ready to kick some ass. You are like, Yeah, we are here to make an impact, right? And then, by the end of the deployment, you are like, it is a quote from the show Step Brothers, where they are like, we are on planet bullshit. And this is whenever, like, they are just pissed at the world, and that is truly like what you go through during the stages on deployment, and you just get to the point where you are just done, like, you just wanna go home, or you are just like over it. And you don't wanna do whatever it is you are doing, like, the routine and whatever. But having your team or people that bring you back to life makes you wonder why you are doing, like, what is the mission? What is the purpose? What are you getting out of this? What is serving your soul? Seeing that in other people and team members picking up each other slacks when somebody is at their lowest impacts me and motivates me.

PT explains above that deployment is exciting at first, but after a while, she became tired of seeing the traumatic clinical conditions for years and wanted to go home. She states that her peers are the ones who support her in seeing the mission of the deployment and the purpose of her job. Such peer support not only energized her to continue her deployment duties but also motivated her to be the nurse she is. Empirical evidence indicates that the described **PT** peer

support is embedded in a strong team integration that motivates and brings military nurses back to life through compassion, kindness, and emotional regulation (Finnegan et al., 2016). Military nurses support their peers when they need it the most.

2. Sub - Theme: Emotional Regulation

"I think that if people didn't have that connection with at least one or two of their coworkers, they probably would suffer from significant mental issues, emotional issues, and burnout and probably would leave whatever care area they were in."

In this study's interviews, military nurses express that the motivation to execute the job of a nurse in the military is supplemented by some peer support as emotional regulation to minimize burnout caused by cumulative workplace stress and culture. **JD** explains:

> Without the support of your peers, when you are going through a lot of emotional turmoil, maybe not personally, but certainly, being a critical care nurse, it will be hard. I have the honor of caring for the patient and their family at the worst moments of their life that takes a toll on us as much as it does them. It wouldn't be the same without a human connection with our peers and coworkers. I think that if people didn't have that connection with at least one or two of their coworkers, they probably would suffer from significant mental issues, emotional issues, and burnout and probably would leave whatever care area they were in. I know, many times, I have been comforted by my coworkers, and I remember comforting one of my friends after a Code blue. She got really close with the patient's family while caring for the patient. We had to Code the

patient, and afterward, she went into the bathroom and was crying. I went and comforted her, and that happens regularly. And I don't really think people know that, but it does.

JD emphasizes above the necessity of frequent peer support, contact, and comfort during stressful and emotional situations in helping military nurses regulate emotions, burnout, mental health challenges, and general well-being. As expressed by **JD** and according to research, emotional regulation is an essential component of public service delivery for public servants such as military nurses (Mastracci, Guy & Newman, 2012). According to the military nurses who participated in this study, this emotional regulation is critical for them to be effective and productive at work since they must be mentally healthy to provide quality care to patients.

In their stories, military nurses express that feelings of reciprocity are also an important part of emotional control. They mention that a peer in the field who understands what they are going through exactly is reassuring and comforting to them. For example, **HW**, a critical care nurse with 3 to 6 years' experience, explains that "when being especially in the military, it helps me to know that I have someone out there who understands what I am going through. And that is really important in the fact that if you have someone who couldn't understand what you are going through, I think that could have affected my mental health." **HW** reflects the importance of peer support, allowing military nurses who understand each other's situations to support one another in regulating their emotions and mental health. **HW**'s reflection is important and powerful because it allows military nurses to develop an awareness of their own emotions, as well as a helpful reaction when dealing with peers' emotions and emotional demands from clinical situations, all of which affect their level of mastery and performance (Lee & Jang, 2019).

Peer support is instrumental in promoting self-awareness, empathy, and skill development among military nurses. By connecting with peers, sharing experiences, and offering mutual support, military nurses not only enhance their own well-being but also strengthen their ability to provide compassionate and effective care to their peers and patients.

3. Sub-Theme: Mastery

"I felt like I understood how the whole process worked, and I gained the confidence to be able to handle more stressful situations and not feel under pressure."

Another prominent theme in interviews with military nurses is mastery. Many military nurses in this study argue that mastery, the necessary skills to succeed in a military nursing profession, is improved through practical formal and informal peer support. For example, **CV,** a medical-surgical nurse with 6 to 12 years of experience, reflects on her experience when she first started her job:

> I remember when I first started in a surgery center. I felt I was kind of really nervous when I first went into my cases, and I was trying to learn the whole process. But then I went to the hospital, got a more in-depth orientation, and went to the reserves. I felt like I kind of put it all together, and I felt like I went from, say, employee to manager, kind of, in that role. In my mind, I felt like I understood how the whole process worked, and I gained the confidence to be able to handle more stressful situations and not feel under

> pressure. I definitely feel like the preceptorship experiences I had prepared me for the role that I am in.

CV highlights above how her preceptorship experiences prepared her to fully understand her role as a nurse in navigating clinically challenging situations and what it takes to accomplish her work effectively, which led to her swiftly obtaining leadership abilities and becoming a nurse manager. Also, in their stories, military nurses express that when they reflect on practice and gain valuable experience, they gain skills that are not comparable to civilian nurses. For example**, JD** explains:

> So, our clinical competency often differs slightly from that of civilian nurses just because we are in the military. For instance, I had the opportunity to go as a brand-new nurse directly into an ICU in Iraq and Afghanistan. It was the busiest military ICU treatment facility at the time, and so I did that. During my orientation or preceptorship, I had a ton of multi-poly trauma and cardiovascular surgery experiences. Because of that preceptorship, time mentorship experience with my nursing peers, and even my superiors, and because of their experience and longevity of being a nurse, I learned everything from them. In nursing, we go to school to learn things like the fundamentals of nursing in books. However, nothing prepares you to take care of an actual patient like being put in that room with that patient and an experienced nurse showing you, telling you, and explaining to you why you are doing what you are doing to help you care for that patient and the patient's family. And your relationship with that preceptor is critical for your learning and success, not just short-term success but also long-term.

JD addresses above how serving in the military affected her capacity to treat patients. She mentions that working in one of the largest ICUs in Afghanistan and Iraq exposed her to preceptorship and mentoring opportunities on multi-poly trauma and cardiovascular surgical practices. She points out that civilian nurses would not have such types of experience and expertise. She also emphasizes that her relationship with her preceptor is an important aspect of these positive experiences since it has impacted her long-term learning and career goals. In fact, peer support (both preceptorship and mentorship), described by **CV** and **JD** above, is referred to as experiential learning. According to Bonner (2001), experiential learning is essential for clinical learning through the theoretical and procedural knowledge acquisition process. Procedural knowledge gained through clinical experience, preceptorship, and mentorship enables military nurses to develop and master the necessary nursing skills while demonstrating competence and leadership.

4. Sub-Theme: Leadership

"When you are in the military you have a lot more independence. A lot more leadership laid on your shoulders."

According to the military nurses who participated in this study, once military nurses reach a certain degree of mastery, they behave clinically differently because they have a new way of thinking about care delivery, are prepared to make decisions and act on them, and can become leaders in their specific nursing field. They further explain that military nurses have more

autonomy to lead than civilian nurses due to that leadership. **DM** well explains this autonomy or independence:

> I had trouble with switching from a military nurse to a civilian one. After coming off of active duty, when you are in the military, you have a lot more independence. A lot more leadership is laid on your shoulders. Yeah, in civilian nursing, you don't always have access to providers; for that reason, it is a lot more independent in the military. And in civilian hospitals, there are a lot of regulations that you have to follow. Otherwise, you don't get reimbursed for the almighty dollar kind of thing. And you know, rightfully so, I understand that. So, it took me a little bit to get used to that, plus some of the roles were a bit different. In the military, just a simple task like starting an IV that really doesn't fall to the nurse. Because it is the combat medic enlisted folks who go out into the combat area who are supposed to be proficient in something like that. So, in the civilian hospital setting, nurses would do something like that, whereas in the military, we are more assessment-oriented and not so task-oriented.

The culture shock from **DM**'s account above reflects how much leadership and autonomy military nurses are given. This reflection is consistent with previous research. Though the degree of autonomy varies among SLBs, military nurses exercise a high level of autonomy since their decisions combine particular cases, specific clinical situations, and licensed plus practical competence (Vedung, 2015). In their stories, military nurses in this study indicate that there is also a shift in military nurses' position once they have demonstrated expertise and competence

by responding efficiently and masterfully to different clinical situations. For example, **MM** confirms that by mentioning that:

> At the beginning of your nursing career in the military, you tend to be more clinical. Typically, you will work in a hospital, taking care of patients and honing your nursing skills. Then, as you progress throughout your career, you are taken out of a clinical setting and put in more of an administrative or leadership role.

MM explains that once military nurses have mastered their nursing abilities, bureaucratic executives will place them in administrative or leadership positions where they may mentor, train, and lead others. The transition of military nurses from clinical to administrative or leadership roles, as reported by **MM,** is consistent with Teodoro's (2009) finding that public officials and bureaucracy do not gravitate toward each other at random. He argues that bureaucratic occupations, such as those in the military, have long-standing procedures of promoting leaders from inside the institution based on their talents and reputation. Teodoro's finding underscores the importance of understanding the non-random relationship between public officials and bureaucracy in shaping governance processes, policy outcomes, and public administration practices. Recognizing the factors that influence this relationship can inform military nurses' leadership efforts to improve public institutions' effectiveness, efficiency, and accountability.

5. <u>Sub-Theme: Sense of Belonging</u>

"I remember, just like even in the midst of all of that we still found ways to still stay close. We did what we could to build morale and build that sense of community on our floor."

Another critical theme in military nurses' interviews is a sense of belonging. Many military nurses in this study argue that their sense of belonging starts with the feeling of understanding one's reputation and role enough to create professional meaning, being comfortable with one's duty, and enjoying the military camaraderie and esprit de corps. Such a sense of belonging is fortified by trust among military nurses. **MM** describes the impact of trust on establishing a sense of belonging:

> So, I was still working inpatient when COVID first hit, and we were one of the first units to take COVID patients within the hospital after the ICU filled up. I think it's almost kind of like trauma bonding essentially because everybody was scared. Nobody knew anything. We didn't really know what we were doing because nobody had seen anything like it before. And we kind of were all forced to really rely on each other and trust that we had each other's best interests and the patients in mind. And there were definitely points in time when people reached their breaking points. I remember, just like even in the midst of all of that, we still found ways to still stay close. We did what we could to build morale and build a sense of community on our floor. And you know you are with these people for 12-plus hours every day. And I definitely think COVID really helped highlight not only the problems that we had within our healthcare system but also how important it is to rely on your coworkers and trust them.

MM's quote describes how peer support allows military nurses to trust and bond under difficult clinical conditions, such as the COVID-19 pandemic. She also states that COVID-19 helped military nurses understand the value of peer support, especially in providing peers with opportunities to boost morale and have a sense of community to safeguard their mental health and well-being. **MM**'s views on the effect of COVID-19 are aligned with previous research. During COVID-19, nurses emphasized peer support and social belonging to establish trust and a support structure among them since they had each other as friends and family to confide in, relieve stress, and improve their well-being (Linos, Ruffini & Wilcoxen, 2021). Peer support enables military nurses in difficult clinical situations to build strong bonds with their peers and create a supportive environment where individuals feel comfortable sharing their challenges, seeking advice, and offering support, fostering a sense of solidarity, understanding, and belonging.

Furthermore, empirical evidence shows that peer support enabled military nurses to improve the health outcomes of COVID-19 patients (Sahay & Wei, 2022). This positive impact refocused the general public's attention in recognizing and supporting nurses for the actual value of their work. **JD** explains:

> I think COVID increased the level of support among nurses. I think that there was a significant lack of support from everybody else, meaning patients, family members, physicians, and the public at large. I think that those people didn't support nurses. I think that nurses support nurses. I think that once we were in the full throws of it, and even coming on the outside of COVID, all of those other people kind of recognized the value of the nurse. Now, I think that it has given us an opportunity to have a seat at the

healthcare table and show our value and worth, and I know that was done through COVID.

JD explains that before COVID-19, military nurses were the only ones who supported their peers, neither physicians nor the general public. She claims that the general public only began to recognize nurses' worth and support them as heroes in the middle or end of the pandemic. She notes that this gave military nurses the legitimacy to sit at the healthcare table. As expressed by **JD**, such legitimacy is consistent with the literature. According to Lipsky (1980) and Rothstein and Teorell (2008), public organizations and SLBs earn legitimacy and trust through the work of SLBs or during their encounters with citizens, affecting citizens' public service experiences. Peer support helps military nurses enhance their well-being and sense of belonging, which in turn helps them improve the health outcomes of citizen clients and the legitimacy of government service.

Theme of Organizational Commitment

Officers in the military are intensely motivated to achieve the military mission and serve the public. Organizational leadership, culture — a meaningful sharing of values among members of a group — and size, on the other hand, impact whether or not these nurses adequately support one another to not only acquire the necessary skills or regulate one’s emotions but also retain one to stay at their job. Firstly, leadership plays a crucial role in shaping military healthcare organizations’ organizational culture, climate, and priorities. Thoughtful, supportive, and empathetic leadership can inspire trust, confidence, and loyalty among military nurses, creating an environment where nurses feel valued, heard, and respected. Secondly, organizational culture

sets the tone for interpersonal relationships, teamwork, and communication within military healthcare settings. A positive and supportive organizational culture that values collaboration, mutual respect, and camaraderie fosters an environment where nurses feel empowered to seek help, share knowledge, and provide emotional support to their colleagues. Conversely, a toxic organizational culture characterized by mistrust and punitive attitudes may hinder nurses' ability to support one another effectively and contribute to high-stress levels, burnout, and turnover among military nursing staff. Lastly, organizational size can influence the accessibility of support networks, resources, and opportunities for professional development within military healthcare organizations. Larger organizations may have more extensive infrastructure, training programs, and personnel to facilitate effective peer support among military nurses. However, larger organizations can also present challenges, such as bureaucratic inefficiencies, communication barriers, and a lack of personalized support for individual nurses. In contrast, smaller military healthcare units may offer a more tight-knit and cohesive environment where nurses have closer relationships with their peers and leaders, fostering a sense of belonging and mutual support that enhances job satisfaction and retention. However, these smaller units may suffer from a significant military nurse shortage. Finally, the interplay between organizational leadership, culture, and size is critical in determining the extent to which military nurses adequately support one another and thrive in their roles within military healthcare organizations. Respectively, the organizational commitment theme has 3 sub-themes: organizational leadership, organizational culture, and peer support program.

1. Sub-Theme: Organizational Culture

"If assholes surround you, that changes how you feel, whether you know that or not."

In this study's interviews, military nurses argue that the military organizational culture was symbolized by esprit de corps — a proud feeling of belonging to a group whose mission you believe in — and camaraderie. They further express that this esprit de corps is usually accompanied by mentorship and peer support. Many military nurses admit that as new nurses, they wanted to join the military for the esprit de corps, but they could not find it. **DM** explains how that feels:

> I was disappointed with the Army Nurse Corps because one of the reasons why I wanted to go into the Nurse Corps was because of the camaraderie, the esprit de corps, and the mentorship. And it was about 2 years or so before I even found somebody who I could remotely call a mentor. It was really kind of sad to me. I guess I had this grandiose, wonderful idea that somebody would just be there, and everybody would just stick together because we are all nurses. But I didn't quite feel that.

DM indicates that she entered the Nurse Corps expecting to discover solidarity with peers and mentors and enjoy the army's brotherhood. Unfortunately, she was frustrated by the lack of mentorship support for about two years. **DM**'s explanation for joining the military is consistent with previous studies. For example, SLBs, particularly those in the military, join public service because of a professional logic known as camaraderie, which focuses on supporting peers while protecting the public interest (Berg & Pinheiro, 2016). The lack of such peer support can be detrimental to the beginning of a nursing career since peer support impacts a nurse's physical,

psychological, and technical work readiness (Cohen et al., 2000). To complicate matters, military nurses state in their stories that even if they find a mentor or peers who support them after years of waiting, they may still not obtain the support they require since people no longer want to help others. **CV** explains:

> I don't feel anything supportive of the organization and the people I work with now. At every workplace, there is some kind of support. They try to put supportive things in place. But it is just hard because there are so many mixed personalities and so many clashes sometimes that I start to feel like I just wanna get to work, do my job, and get out of there. They try to do special things to motivate people, but I don't feel like it is working. This atmosphere makes people want to look at other places or find other opportunities. I feel like people used to want to work together a lot, like to get to the bottom. And now, I feel like people give up quickly and just want to blame somebody else instead of working together…Also, I feel like peer support is dwindling because there are so many shortages and so much turnover.

The **CV**'s description above reflects a deteriorating military nursing organizational culture due to a lack of support, nursing shortages, and inadequate organizational peer support initiatives to retain nurses. As described by **CV** and suggested by the evidence, the desire to find another place to work arises when working in a non-peer-supportive environment (Hayhurst, Saylor & Stuenkel, 2005). Without peer support, this study's military nurses argue they will resign. To make matters worse, the military nurses in this study advise new nurses to reconsider joining the Nurse Corps due to the present organizational culture. **MM** notes:

> I think that if people are interested in military nursing, they weigh their options very carefully. I have only been in for 8 years, but the Navy that I started in and the Navy that I am in now is very different. We are going through many changes right now. I think it is great if people want to join, but I think that they should definitely weigh their options and talk to people who are currently in before making that big decision. As I said, we are going through a lot of organizational changes, and it is very, very different now. And I don't want to discourage people from doing it because the Navy has been so great to me. They have given me so many opportunities, and they have been wonderful, but like I said, it is very different now.

MM suggests above that the Navy's organizational culture is drastically changing for nurses, and she advises new nurses to conduct extensive research about the new organizational culture before joining. Moreover, military nurses in this study who have experienced both positive and negative peer support or supportive and toxic organizational culture believe that as a medical professional, having a culture where one can feel safe and comfortable with others to ask a clinical question or for help turning a patient, or to cover one to go to the bathroom or go to lunch makes a difference. As **JD** explains, "if you don't, that is affecting your psyche, which you are then taking into the room when interacting with your patient and their family member. And so, if assholes surround you, that changes how you feel, whether you know that or not." As **JD** states above, toxic peers or leaders negatively influence military nurses' morale and performance. This statement is confirmed by Reed's (2004) research on toxic leadership in the military. He claims that toxic leaders and organizations have a detrimental influence on the

quality of military personnel decision-making. This claim is particularly crucial for nurses, as their decision actions might mean the difference between life and death for citizen clients. For military nurses, the constant stress, negativity, and lack of support from toxic organizational culture and leadership outweigh any sense of loyalty or commitment to the profession or organization. Nurses may seek employment elsewhere in search of a healthier work environment that values their well-being and contributions. Organizations must prioritize creating a positive and supportive work environment that promotes trust, respect, collaboration, and support among nurses. This process can involve implementing preceptorship and mentoring programs, which prioritize a supportive work environment.

2. Sub-Theme: Organizational Leadership

"I think that having leaders that were open to what my goals were and seeing me do well was so important."

According to military nurses in this study, organizational group members or people create negative organizational changes and differences. For example, **MM** says, "people that I work with and look up to are really the thing that keeps me going because, in my current command, the climate itself is very poor and stressful. If I didn't have the people I work with, I don't think I would have held out for as long as I have." **MM** uses people here to refer to her peers who keep her going and leaders who create a toxic work environment. These leaders may benefit from using the institutional logics perspective in primarily focusing on "persons, not policies…and the promotion and protection of [organization] values [or culture]" (Selznick, 1957, pp. 27-28). Military nurses in this study believe that public leadership's social and cultural

behavior is crucial because it helps maintain and strengthen public service values and empowers and supports them to do their jobs effectively. **PT** describes:

> I think every place is different. Every duty station is a little bit different. Obviously, individual personalities determine a lot of that. Leadership determines a lot of that. I was very fortunate in all of my experiences to have very hands-on leaders and people who were really passionate about being involved. And I think that it is about the people that you are reporting to and looking up to that need to not only just talk the talk but also walk the walk. I think that is really good for setting an example. But they also then encourage you to want to do better and to be better for them and for the team. So, I think that I was very fortunate in that aspect. I had three different leaders at my first command, just because of how things rotated with deployments; all of them were so supportive of the things that I was interested in doing while also meeting the mission. And I think that having leaders who were open to my goals and seeing me do well was so influential. And that was really something that I carried with me when I was precepting new nurses or working with my corpsman. This work might just be for some people showing up to do their job. But to other people, maybe this is their dream, and every single day is an opportunity for them. I think keeping that in perspective is difficult at times. But in the big picture, that is what makes the culture of a unit work well, and as I said, I feel like I was just very fortunate to always be surrounded by people like that, which was a good example for me to pass on to others.

PT outlines above the need for leadership that incorporates a dedication to flexibility, supporting values, and clinical practice outcomes. Such leadership style, she believes, will

cultivate military nurses' long-term interests and motivation for public service. Public leadership, as indicated by **PT** and suggested by research, can be valued-based leadership that is not only a professional peer relationship rather than an authority relationship but also a supportive relationship that can positively affect SLBs' motives and beliefs, as well as increase their own commitment to supporting peers (Zhang et al., 2022). In other words, public leaders may serve as role models and mentors for military nurses by displaying supportive leadership behaviors and practices and sharing their experience and wisdom gained from their professional journeys to help mentees develop a better understanding of themselves and their knowledge. Such understanding will enhance military nurses' resilience and awareness in supporting themselves and their peers while developing and contributing to a continual support, learning, and growth culture.

3. Sub-theme: Peer Support Program

"*People who are going to put the support groups together should know that we just want to be treated with the same respect that we give our patients."*

In their stories, military nurses who participated in this study express that passing on practical learned skills and experiences to future military nurses is an important aspect of military nursing. They further admit that in the current military organizational context, it may be challenging to assist new nurses in acquiring the required skills to avoid burnout and achieve success. However, many military nurses in this study pondered whether a peer support program would be beneficial. They mention that a peer support program with the explicit objective of assisting not just new nurses but also experienced nurses in the pursuit of a quality and effective

healthcare system may work. They believe it must be a program that empowers rather than exploits military nurses' altruism, unlike the healthcare system. **MM** explains:

> I definitely think it is really important to have a support system and to create a peer support program so that nurses can find mentors or preceptors. I think that would be a great idea. I think it is really important for the people who run healthcare facilities to truly see how crucial nurses are to the organization. I mean, I am sure we are in a nursing shortage right now. And I don't think people realize that the reason that there is a shortage is not because people don't want to be nurses. But sometimes organizations take us for granted because our intentions are essentially altruistic. We just want to help people because we want to help people, and we will do that. We will help people until it breaks us or until, you know, we can't anymore. And I think that people tend to take advantage of that. Having a support group will help, but people who are going to put the support groups together should know that we just want to be treated with the same respect that we give our patients.

MM describes how the nursing shortage is caused by healthcare companies exploiting military nurses' inherent urge to care for people while failing to compensate them with the respect and support they require to do their jobs effectively. **MM**'s beliefs about military nurses' altruistic behavior are consistent with the literature. SLBs, such as military nurses, altruistically behave because they feel their work is about self-sacrifice and putting their lives on the line to serve and protect their nation (Cohen & Golan-Nadir, 2020). Because their action requires courage, determination, and sacrifice, military nurses simply ask in return for respect and empowerment.

According to the military nurses in this study, empowering military nurses' altruistic tendencies begins with providing new nurses with the necessary quality experience to be competent in their jobs. In this study, experienced military nurses have recently expressed concern about a drop in the quality of new nurses. **DM** mentions, "I don't know if it is a generational thing…, but there has been a definite decline…I don't know. Maybe what is missing is the mentorship and preceptorship kind of relationship that really is priceless when you are in a career of helping out other people and where life and death matter." Also, they argue that empowering military nurses' altruistic tendencies remains a mechanism for retaining experienced nurses by helping them maintain a healthy mental state through a supportive program, culture, and peer relationships. **CV** explains:

> I think that a peer support program definitely helps. I know the hospital system that I work with now created health coaches for newer nurses who are coming on. And it would be a good program if they stay with new nurses longer. They have it for specific departments, but not every department has it. That is great for the newer nurses, but I feel like they should have that for all the staff that comes in, even for their seasoned nurses or whatever their medical role is. They should have somebody they feel like they can go to for anything because it makes a big difference.

CV illustrates above how having a longer preceptorship, coaching, or mentorship program for new nurses in every department and military hospital can benefit both new and experienced military nurses by allowing new nurses to understand their jobs and experienced nurses to thrive. Finally, as explained by both **DM** and **CV**, as well as demonstrated by research, the

combination of preceptorship and mentorship not only gives new nurses a place to grow but also a place where experienced nurses can thrive (Mead & MacNeil, 2006). In fact, military nurses in this study demonstrate that preceptorship and mentorship help new nurses expand their clinical knowledge, refine their critical thinking skills, and stay abreast of best practices in nursing. They also describe how mentors, preceptors, or experienced nurses improve their communication, leadership, and coaching skills as they advise and support new nurses. A hybrid preceptorship and mentorship program creates a symbiotic relationship between new and experienced military nurses, fostering a culture of collaboration, learning, support, and growth within the nursing profession. By providing a supportive environment where new and experienced nurses can thrive, the hybrid preceptorship and mentorship program can contribute to nurses' retention, satisfaction, and success at all stages of their careers.

Emergency Nurses' Narratives

I interviewed three male and four female emergency nurses who work in public hospitals: **OP** is a white male from western New York; **QE** and **CB** are two black females from northern Texas; from southern California are **RD**, a black male, and **NZ**, a black female; **UV** is a white female from eastern Florida; and **GM i**s a black male from western North Carolina. Many of this study's emergency nurses wanted to join the emergency department because they thrive under pressure. **QE,** a female with 3 to 6 six years of emergency room (ER) experience, notes, "I feel like I have had a passion for helping people since I was young in terms of medicine because I thrive working under pressure. I love that. I am able to help people get better in urgent and life-threatening situations. I feel like that is my purpose, and it really fulfills me." For the emergency

nurses in this study, being a driven emergency nurse is founded on the public service motivation of saving people's lives, just like other SLBs. In their stories, the emergency nurses in this study believe that saving people's lives in the ER entails giving people with various emergency conditions, such as broken bones, gunshot wounds, and head traumas, a chance to live. **GM**, a male with 2 to 5 years of ER experience, expresses why emergency nursing is important: "I can personally say that I feel like every time I treat someone in an emergency room, that means I am saving a life. And I am giving someone a chance…to someone to continue with the treatment and be able to return home to their normal life."

Helping individuals return to their normal or everyday lives is a worthy goal for the emergency nurses who participated in this study, but they admit it is a challenging task. They argue that it necessitates a more profound knowledge of their role as empathic and compassionate nurses, primarily in the ER, to care for their patients. **UV**, a female with 1 to 2 years of ER experience, mentions, "I am very empathetic and caring. I think what makes me different is that I don't see this job as a paycheck, although the money can be nice, especially if you are on call. But I just care about my patients' well-being and what we do to serve them and help them feel better. And I hope that when I care for them, they feel better than when they first saw me, and nine times out of ten, that happens." In their interviews, the emergency nurses in this study state that they find optimism in caring for their patients and watching them smile. They further explain that they are encouraged and intrinsically rewarded when receiving positive feedback from patients, knowing that they are delivering the best care possible to improve their patients' lives (Maynard-Moody & Musheno, 2003). **CB**, a female with 5 to 10 years of ER experience, explains:

> Nursing is really rewarding. The first thing is when I was growing up, I really wanted to be a nurse. So, I was passionate about doing this work. I want to help people. I want to see people smile. I want to, like, help a boy in pain, and, in the end, when this patient is going out of the hospital, he smiles and says thank you very much. I really appreciate the smiles on their faces; they keep me going. I am like, yeah, I achieved what I wanted.

CB describes above that she enjoys helping others and considers her profession satisfying since it makes people happy and smile. Furthermore, in their interviews, emergency nurses explain that what distinguishes them from other nurses is that they are on the frontlines of healthcare in civilian hospitals. Emergency nurses must undergo extensive on-the-job training, enhancing their skills and passion for their work (Helbing et al., 2017). **OP**, a male with 7 to 15 years of ER experience, explains that "there is no formal education required to be an ER nurse pretty much as long as you have a nursing license. But there is a significant amount of on-the-job training that is required in order to be an effective one." Such training starts with "6 to 8 weeks of class work, which our hospital requires. Then it is about weeks of trauma training, all the way from pediatrics to gunshot wounds, to stabbings, to disaster training, and to how we effectively handle patients," says **UV** when she started as a new graduate without any emergency background. **UV** explains how her hospital wanted to train her in ER best practices so she could understand how she prioritizes patients in the ER and how to care for them successfully.

In their stories, emergency nurses believe that in the ER, it does not matter if patients are in tremendous pain; what counts is who can die first and be treated immediately. **UV** further

expresses that this is one of the key reasons why emergency nursing differs because she will first care for “someone who is in a full cardiac arrest with active compressions and wait to take care of a patient that is in 10 out of 10 pain, unfortunately, because the first patient needs her help more.” Along with these vital lifesaving and assessment abilities, this study’s emergency nurses fortify their differences by stating that they can perform IVs, blood sampling, EKGs, and other tasks that regular nurses may have difficulties performing. With unique skills and being at the frontline of civilian health care, emergency nurses in this study highlight the impact of peer support - preceptorship or mentorship - on their job in two themes: Professional meaning and organizational commitment.

Theme of Professional Meaning

Both formal or preceptorship and informal or mentorship peer support enable emergency nurses to gain professional identity, competence, psychological safety, and professional meaning. By engaging in skill-building exercises and hands-on learning experiences under the guidance of their preceptors or mentors, emergency nurses develop the confidence, proficiency, mastery, and resilience needed to excel in their roles and uphold the highest standards of patient care. Additionally, preceptorship and mentorship create a supportive and nurturing environment where emergency nurses feel psychologically safe taking risks, making mistakes, and learning from their own and peers’ experiences. This psychological safety enables nurses to share their concerns openly, seek help when needed, and engage in continuous learning and improvement. Moreover, peer support fosters a sense of belonging and connection among emergency nurses, helping them to forge meaningful relationships with their peers and cultivate a shared sense of

purpose. Such a shared sense of purpose enables emergency nurses to thrive in their roles, find meaning in their profession, and make meaningful contributions to the well-being of their patients and peers. Therefore, four sub-themes emerge for the professional meaning theme: peer support, personal/professional identity, mastery, and psychological safety.

1. Sub-Theme: Peer Support

"Preceptorship teaches you how to do a job, but mentorship teaches you how to live that job or live that career."

In their interviews, emergency nurses express that they are the patient's first point of contact when entering the civilian medical sector because they have been trained to distinguish between patients who are unwell and require immediate medical assistance and those who can wait a little longer. This study's emergency nurses state that they gained these skills through formal (preceptorship) and/or informal (mentorship) peer support or training. Many emergency nurses in this study report receiving multiple formal and informal training to be effective in their jobs, and they understand the value of mentorship and how it differs from preceptorship. For example, **OP** emphasizes the distinction between mentorship and preceptorship below:

> I currently work at a small community hospital and have a student in training. He is a nurse practitioner student. Currently, he works in the ER and is kind of not new to nursing. He actually came from the same hospital where I used to work. And now, he is

working at that same community hospital. He has so much potential, but the problem is he thinks he is much better than he is. And so, he has actually started to burn a lot of bridges just because he thinks that he is a nurse practitioner student who knows better than people who are functioning as nurse practitioners or administrators, things like that. Well, I also own a small practice in a community setting as a nurse practitioner, and so he kind of clung to me and asked for a lot of that mentorship, like, 'Hey! How can I get to where you are?' type thing. Different from mentorship, preceptorship would be okay here because this is a formal setup to teach you how to be a nurse, but it doesn't teach you how to form your career, so to speak. You know, preceptorship teaches you how to do a job, but mentorship teaches you how to live that job or live that career. Because he already knows how to be an ER nurse, he is already on his own as an ER nurse, but he doesn't know how to progress his career at all. And so that is kind of where that mentorship came in. To be honest, I had zero interest in being a mentor to him initially because he is cocky. But after talking a little bit with him, I have not formally agreed to be a mentor or anything like that, but I have kind of taken him under my wing. It has just been like, hey, so and so, look, you can't do that, man. Think about how that looks from other people's perspectives. If you were a nurse practitioner, would you want a nurse coming up to you and telling you how to do your job? No, he said. I told him, I understand you're a student, but you gotta put in your time first, and you will get there. You will practice this first. Let's come up with a game plan. Let's make this more effective than it currently is. And I think he has responded positively to it. I mean, he still has a road to travel, but I think he is getting better.

OP uses one of his mentees to demonstrate the difference between preceptorship and mentoring. As he puts it, preceptorship teaches a person how to execute a profession, whereas mentoring teaches how to succeed professionally. However, he emphasizes that being an effective emergency nurse requires a combination of both. The combination of preceptorship and mentorship in emergency nursing, as explained by **OP** and demonstrated by research, is vital because exercising skills discretion through on-the-job training to teach and learn most of what is done in the ER shapes emergency nurses' professional identity and their passion for providing adequate emergency care (Rantung et al., 2022). A hybrid peer support model that includes preceptorship and mentorship assists emergency nurses in developing the skills, passion, and character required to perform their duties successfully.

2. Sub-Theme: Personal/Professional Identity

"Peer support is why I am the person I am and why I am working as an emergency nurse."

According to the emergency nurses in this study, regardless of the distinction between preceptorship and mentorship, peer support, in general, enables them to develop a personal and professional identity in order to establish professional meaning. For example, GM mentions that "peer support is why I am the person I am and why I am working as an emergency nurse to give my best, to work for long hours, and sometimes extra hours. It gave me the main reason and motivation to see someone recover and not lose them." As GM explains, peer support enables emergency nurses to show up at work with their best selves and do their best to save patients' lives. Doing their best, expresses NZ, a female emergency nurse with 2 to 7 years' experience, is "risking their lives to save other people's lives, not only because of their training but also their

trainers [preceptors or mentors].” NZ stresses emergency nurses’ altruistic behaviors and, most importantly, supportive relationships with their preceptors or mentors. She believes this relationship impacts how successfully emergency nurses accomplish their jobs. Indeed, through peer support, healthy professional relationships between preceptors/mentors and mentees/preceptees affect mentees’ self-efficacy, feeling of knowing the nursing profession, and professional identity (Omer & Moola, 2019). **UV** further mentions:

> I have a nurse friend with whom I became friends, who was my preceptor during my training and has 25 years of experience as a nurse. As someone who was an LPN first and then basically a baby nurse, I just look up to her so much. She has so much knowledge. She has so much experience. I am almost on the verge of burnout, and I have only been a nurse for a year in the ER setting. I asked her the other day if she had ever felt this when she first started out. Is this normal? She said, yeah, like, what you are going through is normal. There is a 6-month trial period where you kind of struggle. And then there is the year mark where you struggle. She has given me a lot of tools to work with, and just by how smart she is with everything, I look up to her completely.

UV recounts above how her remarkable relationship with her preceptor resulted in friendship, less burnout, and idolization of the preceptor. Such idolization and reliance on preceptor abilities, the emergency nurses in this study express, not only help them develop their personal and professional identities but also allow them to find meaning in their work because they cannot envision themselves doing any other nursing job. **OP** elaborates:

> Emergency management is absolutely a public health endeavor just as much as it is acute care. And I love that kind of marriage between the two concepts. I love being able to care for somebody, fix their problem, and send them on their way, which is something that I could never see myself not doing. I indicated at the beginning that I have tried a number of different nursing fields, including critical care, medical-surgical, and things like that. But you know, all those jobs just get monotonous, and there are only so many times you can walk somebody around a unit without wanting to stab your eyes out with work. I think it is just the perfect marriage of all of those different concepts in the ER without any of the monotony that makes me want to stay in the nursing profession.

OP argues above that after acquiring the essential skills to be an emergency nurse, it is difficult not to feel passionate about one's job. He recalls that he has tried numerous nursing fields, but none of them equal the feelings and benefits he gets from emergency nursing. As expressed by **OP** and evidenced by research, the majority of SLBs, particularly emergency nurses, are passionate about their work because they possess the necessary skills to help and save citizens' lives (Maynard-Moody & Musheno, 2022). Through peer support, emergency nurses develop the necessary skills to do their job and a sense of professional identity rooted in the values and standards of emergency nursing practice.

3. <u>Sub-Theme: Mastery</u>

"Thanks to my preceptorship, I became a much more confident nurse."

In their stories, this study's emergency nurses argue that their professional meaning is enhanced by their confidence and capability to do their work. Gaining that confidence, skills, and mastery in emergency nursing is "very, very vital because ER is the first care where a quick diagnosis and response is needed to refer patients to any other unit," **RD**, an emergency male nurse with 3 to 6 years' experience, mentions. Emergency nurses in this study mention that such skill and mastery are a result of formal or informal peer support. **GM** describes:

> Yes, my mentorship experience proved to be valuable during my early days because I was new. For the first three months, I had a mentor with over two decades of experience who guided me through the intricate dynamic of our profession in person and through regular meetings, constructive feedback sessions, and shadowing opportunities. I gained a deep understanding of the best practices, effective patient communication, and advanced procedures. And I feel like this mentorship also equipped me with soft skills like conflict resolution, teamwork, and decision-making. My mentor has been a guide and instrumental in my professional journey by helping me confidently face ER challenges.

Given that all emergency nurses in this research received some sort of official training, **GM** emphasizes the value of formal and informal peer support by concentrating on the critical skills he learned from his mentor, which gives him confidence in his abilities. Such confidence in one's abilities and competence, the emergency nurses in this study believe, assists them in dealing effectively with a variety of ER situations. For instance, **OP** mentions:

> My preceptorship made me feel a lot more confident as a nurse and made it so that I felt like I could better accomplish other people or other tasks like IV placement. For example, one of the most important things I teach when teaching others is confidence. If that confidence is not built, you are significantly less effective as a nurse or just a healthcare worker in general. So, thanks to my preceptorship, I became a much more confident nurse. I identified some weaknesses and kind of exploited those and made sure that I was the best team player possible for the team.

OP states above that the confidence he received from preceptorship inspired him to educate peers on the importance of confidence in emergency nurses to accomplish their jobs efficiently. Many emergency nurses who participated in this study explain that mentorship or preceptorship provides them with the skills they need to be effective and allows them to collaborate in a supportive and positive environment. **QE**, a female emergency nurse with 3 to 6 years of experience, feels that "[mentorship and preceptorship] really help. When you have a mentor or a preceptor at your workplace, they help create a positive work culture. Also, working with them makes me feel more confident in my abilities and acclimates me to the work environment climate."

QE describes above the crucial role mentors play in developing skilled emergency nurses in a supportive setting. Also, **QE**'s description of a mentor or preceptor role aligns with previous research. Evidence shows that formal and informal peer support (preceptorship and mentorship) creates a positive and supportive environment that prioritizes SLBs' well-being, improves their performance, and allows them to enjoy psychological safety (Destler, 2017). By fostering a

supportive environment, a hybrid preceptorship and mentorship program contributes to the overall success and well-being of emergency nurses working in the fast-paced and demanding ER.

4. Sub-Theme: Psychological Safety

"When the work environment is a safe space, you feel like you want to do good work and are motivated to work as compared to a toxic environment."

Another prominent theme in this study's interviews with emergency nurses is psychology safety. According to the emergency nurses in this study, psychological safety is not equal to having autonomy. **RD** explains that emergency nurses "may have some level of authority but not have complete autonomy" when doing their job. This limitation of complete autonomy at the frontline is not new, as SLBs' choice is always embedded in a procedural structure. For example, Lipsky's (2010) updated SLB concept places SLBs on a continuum of work occupations and experiences that result in contextual stress, under-resourcing, and a balance between job expectations and effective practice. That is, SLBs' choices are influenced by the complex interplay between procedural structures and the immediate context in which they operate. This context includes factors such as resource constraints, workload pressures, client demands, and interpersonal dynamics within the workplace. SLBs must navigate these contextual challenges while adhering to procedural requirements, leading to a constant negotiation between following formal rules and responding flexibly to the needs of clients and the demands of their work environments. Lipsky's framework highlights the dynamic and multifaceted nature of street-level

bureaucracy, where public servants' choices are shaped by formal structures, workplace climate, and real-world constraints, ultimately influencing the quality and outcomes of public service delivery. A positive workplace climate is important among the emergency nurses interviewed for this study. They believe it is the prerequisite for them to feel safe enough to engage in formal and informal interactions, resulting in them enjoying their profession. **CB** explains:

> Now, for instance, when you have friends from work, at least sometimes of the day, you just chitchat, laugh, and catch up about what you are doing. How is life? So, it is not like that work environment where you just go to work because you are working. We have a kind of social life in the workplace that makes us feel safe and interact formally and informally. When the work environment is a safe space, you feel like you want to do good work and are motivated to work compared to a toxic environment. So, I feel like peer support makes a workplace more enjoyable. I have the motivation to wake up and go to work because I know if I need to talk to these people in case of anything, it feels safe to do so. I feel like we connect in both dimensions, in the workplace and also outside work because my best friend is also a nurse. So, it is important to connect in both dimensions and feel safe.

Above, **CB** describes how peer support allows emergency nurses to interact with peers professionally and outside of work. Such peer support creates bonds inside or outside work, resulting in a supportive, motivating, fun, and psychologically safe workplace environment. The emergency nurses interviewed for this study express a shared sense of psychological safety, which permits them to not only enjoy and grow in their work environment but also to recharge

their minds through emotional regulation when they support one another professionally and emotionally. Subsequently, they believe they can deal with themselves first before dealing with patients in order to provide quality care. **CB** further explains:

> My peers provided emotional support in a safe and empathetic space by allowing me to express my emotions. Telling a work friend about what I felt, venting my feelings, and trying to understand what I was going through was supportive to me. Talking to her helped reduce my stress. At the time, I was looking for stress management because it was when there were patients who were seriously injured. The police car brought them to the hospital, and I don't know how their family knew about it, but they were all immediately at the hospital, overreacting. They were up and down, asking if they would be okay. What is going to happen to them? Are they in a stable condition? We were trying to provide first aid to them, and one had a head injury and the other one a leg injury. So, we were trying to start prioritizing depending on the impact of the injury. So, you have to start with the person who had a head injury before you get to the leg and everything. Afterward, they were treated, and they were in a stable condition. It was during my first year of nursing, and I was so traumatized. I felt like I was working under pressure, and it was my first time. After I finished with them, I just sat in my place of work and started crying. It really brought out a lot of my emotions. She provided emotional support. She told me that is normal.

For **CB**, peer support means emotional support, a safe place to cry, and empathic peers on whom one may rely to help regulate emotions and reduce stress. **CB** also emphasizes that obtaining emotional support is a completely normal and vital part of emergency nurses' well-

being. **CB**'s description of the normalcy of receiving emotional support in the ER is consistent with existing literature. Several emergency nurses interviewed for this study reported encountering intense traumatic and emotional experiences daily. Recognizing the importance of employee support during such intense emotional experiences, hospitals such as the Johns Hopkins Hospital in Baltimore established peer support programs such as Resilience in Stressful Events (RISE), which allow peers to provide emotional and social support for one another's well-being (Carvello et al., 2019). Emergency nurses in this study show that peer support provides them with coping mechanisms, emotional resilience, and psychological safety by allowing them to share their experiences, vent frustrations, and seek advice or give support from or to peers who understand their unique challenges.

Theme of Organizational Commitment

The organizational commitment of emergency nurses is seen in their level of engagement and commitment to their profession and peers. Emergency nurses prioritize building supportive relationships with their peers, fostering a culture of teamwork, mutual respect, and solidarity in delivering high-quality care within the fast-paced and high-stress environment of the emergency department. Working collaboratively with their peers allows emergency nurses to leverage their collective expertise, insights, and resources to address complex patient needs, navigate challenging situations, and provide effective patient-centered care. Therefore, emergency nurses' commitment to developing supportive relationships with peers extends beyond individual interactions to collective efforts to improve the overall quality of care and promote a positive

work environment. Recognizing the interconnectedness of their roles and responsibilities, emergency nurses collaborate with peers on quality improvement initiatives and best practice guidelines designed to enhance patient care delivery and optimize clinical outcomes. As a result, emergency nurses reflect their profound commitment to their profession by supporting their peers in fast-paced and high-stress conditions to deliver quality patient care. Respectively, the organizational commitment theme has two sub-themes: peer commitment and peer support program.

1. Sub-Theme: Peer Commitment

"The simple fact that I had such an enthusiastic preceptor made me more interested in passing that on to others."

In this study's interviews, emergency nurses indicate that they do not see themselves doing anything else since they believe they have the skills and determination to save lives on the frontlines. They believe that they are dedicated to their work and, more importantly, to their peers because they want to ensure their peers are supported from the outset of their careers. They also claim that peer support was given to them as a gift to their peers since they were fortunate to have preceptors and mentors who influenced their successful careers. For example, **OP** mentions, "I think if I had a lesser preceptor, I would be more in survival mode and less interested in this job. The simple fact that I had such an enthusiastic preceptor made me more interested in passing that on to others and made me more interested in being a team player."

OP describes above that peer support enables emergency nurses to be motivated, team players, and proficient in their jobs. Moreover, many emergency nurses in this study report that being a team player and patient is essential when working with newly graduated nurses since it allows them to build a personal and professional identity and stay at their jobs. **UV** states:

> Yeah, definitely, I would love to mentor someone nervous and fresh out of school. You do get anxious in this job, even in a trauma setting. I do feel anxious, but that is also so important because you are more on guard and watching out for what you need to watch out for. But I definitely would love to help an upcoming nurse at some point. Show them how to do certain things. I would love to be patient and nurturing and help them not be afraid to ask me questions because I would love to support someone in that setting.

UV, a newer emergency nurse, emphasizes the importance of supporting new emergency nurses by giving them the opportunity to ask questions that decrease the anxiety and emotional stress within the ER. The experiences articulated by **OP** and **UV** are consistent with research. For example, Omer and Moola (2019) evaluate data from 34 preceptorship program participants, which include clinical teaching assistants, clinical professionals, and preceptees. They find that combining preceptorship with some level of informal mentorship helps avoid challenges in developing healthy relationships between preceptors and preceptees. It also allows nurses to receive clinical experience and emotional support in realizing that being a first-time nurse is scary and the need to help peers avoid that scary experience. New emergency nurses receive professional guidance, expertise, and emotional support by developing healthy relations with preceptors or mentors. Consequently, preceptorship and mentorship programs are critical in

supporting new emergency nurses as they transition into their roles, allowing them to avoid the intimidating experience of being a new nurse and empowering them to thrive.

2. Sub-Theme: Peer Support Program

"If you could create a peer support program that actually empowers ER nurses …that would be huge and game-changing for the emergency department."

The emergency nurses who participated in this study report that having a peer support program can be beneficial because they want to support their peers, especially those new to the field. In their interviews, many emergency nurses who participated in this study agreed that their hospital has some sort of peer support program in place. However, they believe these peer support programs are either too short to support nurses to avoid burnout practically or that they simply do not work. **UV** states why her hospital peer support program is too short: "I think the peer support program that we have at the hospital could have gone on a little bit longer. I think it shouldn't stop for six months. It should go for the full year because right now, more than ever, I need someone to help me not feel burnout and tell me what they did to combat it." **UV** is an excellent example since she is new to emergency nursing and describes above how she feels burnt out and wants more help, but the peer support program has ended.

Many emergency nurses interviewed for this study voice similar sentiments to **UV**'s statement; however, they caution and offer suggestions on how to make a peer support program in the ER successful. **OP** explains below the route to a successful ER peer support program:

> I think that a peer support program is something that, if you have somebody with the right drive, perspective, and interest, absolutely something beneficial could come to light. The problem is that most of the people who currently utilize support structures are the ones going to complain anyway. If you could create a peer support program that actually empowers ER nurses to say, 'Hey, I am actually here for you. We are going to make actionable changes. We are going to make it so that you are supported and empowered.' If you could effectively create that, then absolutely, that would be huge and game-changing for the emergency department.

OP suggests above that emergency nurses must feel supported and empowered for a peer support program to be effective in the ER. **OP**'s suggestion that a successful peer support system should be based on a supportive and empowering structure is consistent with existing research. For example, analysis of the implementation of peer support programs developed by the Johns Hopkins Hospital in Baltimore, Hackensack University Medical Center (HUMC) in New Jersey, and the Regional Emergency Urgency Association (AREU) in Lombardy, Italy, finds that peer support can improve nurses' emotional states and technical skills by supporting and empowering them (Carvello et al., 2019). In other words, peer support programs are a valuable investment for healthcare organizations seeking to support their nursing workforce by empowering and promoting their well-being and retention for improved patient care delivery.

Conclusion

Two overarching themes emerge from this study's findings — professional meaning and organizational commitment — with multiple sub-themes that reflect the lived experiences of its research participants. This study follows Connelly and Clandinin's (2006) narrative framework. It reflects on the stories of mental health, military, and emergency nurses regarding the impact of peer support on their professional meaning and organizational commitment.

This study first focuses on the social aspects of peer support within the stories of the different nurses who participated in this study. These aspects first reveal how these different types of nurses conceptualize peer support in their field. For example, mental health nurses in this study regard peer support as a kind of teamwork when in complex clinical situations and can use their skills together to save lives. The military nurses in this study view peer support as a tool to help their peers when they are most in need. In this study, emergency nurses perceive peer support as a coping mechanism that enables them to gain emotional resilience and psychological safety by sharing their experiences, venting their frustrations, and seeking advice from or offering support to peers who understand the unique challenges they face. Second, consider how formal or informal peer support, preceptorship, and/or mentoring contribute to developing professional skills, identity, and commitment among the nurses in this study. For example, this study's mental health, military, and emergency nurses voice similar benefits of preceptorship and mentorship. They feel that preceptorship provides new nurses with advice, support, and hands-on learning experiences in clinical settings. Also, they feel that mentorship gives a platform for addressing professional challenges and getting constructive criticism, which promotes self-

awareness and confidence in one's nursing identity. Overall, they believe that preceptorship and mentoring programs contribute considerably to nurses' professional growth and development, providing them with the skills, identity, and dedication required to flourish in their professions and make significant contributions to healthcare delivery. Third, the different types of nurses in this study develop a commitment to peers and the job through motivation from mentors/preceptors or role models, peers, and patients. For example, this study's different types of nurses similarly express that both preceptorship and mentorship allow new nurses to observe and emulate the behaviors and practices of experienced nurses, thereby accelerating their acquisition of clinical skills and knowledge. They also believe that a positive preceptorship and/or mentorship relationship instills a sense of commitment to the nursing profession by reinforcing their professional values and standards of practice. Preceptors/Mentors serve as role models who exemplify professionalism, compassion, and dedication to patient-centered care, inspiring preceptees/mentees to uphold these ideals throughout their nursing careers.

Second, using Connelly and Clandinin's (2006) narrative framework also allows this study to shine a light on this study's participants' experiences in several dimensions, concentrating on the past, present, and future. For example, many experienced nurses in this study reflect on their past involvement with the preceptorship and mentoring programs. They argue that the training they had in the past provided them with the skills necessary to flourish and succeed in their jobs today. As a result, this successful career path and training inspire them to teach new nurses skills they know will be indispensable not just for their success but also for the future of healthcare delivery.

Lastly, Connelly and Clandinin's (2006) narrative framework permits this study to give a voice to the lived experiences of mental health, military, and emergency nurses who participated in this study, bringing new perspectives emphasizing the healthcare organizational culture, setting, and leadership styles that hinder or promote peer support or a supportive workplace that empowers and enhances the well-being and retention of this study's mental health, military, and emergency nurses.

The following chapter builds on and extends the findings outlined above into a larger narrative about the impact of peer support on this study's participants' personal/professional lives, as well as their clinical actions to support and care to save lives. This larger narrative is important because it allows this study to identify common themes across mental health, military, and emergency nurses about the influence of formal and informal peer support on their professional meaning, organizational commitment, and current careers. It also permits this study to describe how the different types of nurses in this study find professional meaning in co-supporting care with peers and feel accountable for peers' professional development and actions. Finally, it enables this study to explain both the performative and transformational components of peer support.

CHAPTER FIVE: DISCUSSION

This study uses Connelly and Clandinin's (2006) narrative framework to analyze and reconstruct the stories of mental health, military, and emergency nurses about their peer support experiences to highlight more considerable significance. In reconstructing, this study exposes the larger narrative their stories build together. I interviewed 21 participants and probed their stories to bring new perspectives to what is generally overlooked, with a particular focus on the unconscious frames through which nurses engage with one another to develop professional meaning and organizational commitment through peer support. This study then explores the impact of peer support on the professional meaning and organizational commitment of military, mental health, and emergency nurses. The findings provided in Chapter Four are based on stories told by 21 military, mental health, and emergency nurses, as well as my research notes. The common themes and sub-themes that emerged from the interviews of this study's different types of nurses are presented in **Table 5** below.

Common Themes

The stories of mental health, military, and emergency nurses all took place in clinical settings or public hospitals. Also, the time sequence of these stories is fluid. They all narrate their lived experiences as a flashback to when they were new nurses before receiving formal peer support or preceptorship and/or informal peer support or mentorship and how peer support is

currently affecting their careers. For example, many of the nurses in this study want to mentor or precept new nurses to help them avoid burnout and thrive in the nursing profession.

This willingness to give back to mentees or preceptors stems from their own mentorship and preceptorship experiences. The three types of nurses in this study have social relationships with their peers, preceptors, or mentors that strengthen their professional meaning and their dedication to their peers. Mental health nurses' desire to be nurses began when they were young and has remained because of their commitment to saving people's lives. Such commitment was increased when they developed their abilities through formal and/or informal peer support. Military nurses, like mental health nurses, benefited from formal and/or informal peer support, allowing them to be skilled and save the lives of their unique population: "the sisters and brothers of the uniform."

Saving lives is a common thread for emergency nurses as well because they place themselves on the frontlines of civilian healthcare following extensive formal and informal peer support to give trauma patients a chance at life. They all tell stories of how peer support, both formal and informal, shaped who they are now, both personally and professionally, and how they see the future of nursing through peer support. While the time, social environment, and location give context for military, mental health, and emergency nurses, their stories are best portrayed through the discovered themes: professional purpose and organizational commitment (see **Table 5** for more information).

Table 5: Common Themes and Sub-Themes for Mental Health, Military, and Emergency Nurses

Themes	Sub-themes	Mental Health Nurses Coverage	Military Nurses Coverage	Emergency Nurses Coverage
Professional Meaning				
	Peer Support	**X**	**X**	**X**
	Sense of Belonging	**X**	**X**	**X**
	Mastery	**X**	**X**	**X**
	Personal/Professional Identity	X		X
	Psychological Safety			X
	Professional Purpose	X		
	Autonomy	X		
	Emotional Regulation		X	
	Leadership		X	
	Motivation	X		
Organizational Commitment				
	Peer Commitment	**X**	**X**	**X**
	Peer Support Program	**X**	**X**	**X**
	Professional Commitment	X		
	Organizational Leadership		X	
	Organizational Culture		X	

Note: X indicates the themes that emerged in interviews with each type of nurse in the above table. The common themes across all types of nurses are bolded.

Mental health, military, and emergency nurses share the above-mentioned themes and sub-themes. These bolded themes are the common threads of these nurses' stories, as further explained below.

Professional Meaning: Co-supporting Quality Care

Many nurses who participated in this study indicated that after their preceptorship or mentorship training, they experienced professional meaning by co-supporting care with peers in ways they had not done previously, shifting from individual expertise to collective expertise through teamwork. For example, their stories emphasize individual aspiration and expertise, such as, “I do this job because I needed this kind of help when I was younger; it just pushed me towards this kind of job,” says AB, a mental health nurse. Moreover, an emergency nurse, OP, describes his love for his profession and expertise by saying, “I love being able to care for somebody, fix their problem, and send them on their way, which is something that I could never see myself not doing.” However, these nurses’ narratives depart from “I” to describe a newfound sense of belonging and professional meaning when collaboratively caring alongside peers. For example, ZW, a mental health nurse, mentions, “it is our little world. No one else is clued in. You are kind of isolated in it.” She further expresses that “I am not at my job because I love the organization. I am at my job because I love the children I care for and my co-workers.” MM, a military nurse, also adds, “we will help people until it breaks us” and “we had each other’s best interests and the patients in mind.” This shift from “I” to “we” marks a pivotal moment in their narratives, symbolizing the evolution from personal achievement to collective excellence. The collective stories of these nurses embody a compelling narrative structure, illustrating their journey from the outset of their careers to the pinnacle of their professional growth.

According to this study’s findings, the impact of a mentorship or/and preceptorship is best illustrated for mental health nurses in patient care and teamwork situations, where knowing each other or even communicating verbally may not be necessary because it is a practical and clinical

interaction of skills. Such clinical interaction of skills is the outcome of mental health nurses developing their personal and professional identities based on preceptorship or mentorship to recognize that they are "not perfect" on their own, "but they can help each other to be perfect." That teamwork or camaraderie molds the personal and professional identities of military nurses as well because their commitment to serve our country is profoundly anchored in the camaraderie that characterizes the military. Without such camaraderie or collaboration that fosters the human connection between peers, "people would suffer from significant mental issues, emotional issues, burn out, and probably would not be able to deliver care and would leave the military." Collective care delivery is what happens in emergency departments to save the lives of severely ill people. Collective caring does not exist in the absence of collective identity. Using the social perspective, emergency nurses' personal and professional identities are shaped by their interactions with both the emergency department and their peers. Emergency nurses, for example, like mental health and military nurses, admire the skills of their preceptors or mentors and rely on them to create their personal and professional identities and find meaning in saving lives.

Mastery, the necessary skills to do one's job, is at the base of most of this study's nurses' collective goal of saving lives. Mental health nurses believe that with adequate preceptorship or mentorship, they not only gain self-worth and the necessary skills to do their job but also "feel re-energized" to apply them. Similarly, military nurses gain unique skills that prepare them for saving lives in the states and out on deployments. Being able to be deployed as a new nurse in ICUs located in war zones such as Iraq and Afghanistan provides military nurses with the necessary abilities to save the lives of injured fighters and individuals affected by natural

disasters. Emergency nurses treat victims of disasters and critical incidents because they have a "significant amount of on-the-job training required" to be skilled at their job.

For a number of nurses in this study, gaining mastery or being skilled at their job requires peer support, either preceptorship or mentorship. In their stories, mental health nurses use peer support not only to get through the difficult initial years of their careers or to learn crucial skills but also to develop relationships with their peers that make them feel like they can "do whatever they set their minds to." Being able to perform anything your job requires is why peer support in the military is so structured. This structured framework helps military nurses maintain a constant level of work quality that represents the military mission and their commitment to serving the nation. Finally, peer support for emergency nurses is essential because the majority of what they perform as work is learned on the job.

In their setting, this study's mental health nurses conceptualize autonomy as doing their job without being bound by strict client service protocols and simply exercising their abilities. It is worth noting that autonomy is not a common theme across all types of nurses. However, its mention here underscores mastery's impact in granting autonomy within a particular organizational context. In their context, military nurses in this study have considerable autonomy since they move from clinical to administrative duties as they advance in their careers. Therefore, military nurses take on leadership positions and make various action decisions. Furthermore, emergency nurses have "some level of autonomy" to take control and respond quickly to complex and challenging emergency clinical situations.

Finally, many of these nurses experience a sense of belonging when they bond over shared traumas with peers that characterize their work. Many mental health nurses find that

interacting with their peers helps them to regulate their emotions. Furthermore, COVID-19 forged an unshakable connection among military and mental health nurses. Many of these nurses regard their peers as family and friends, especially emergency nurses, because they rely on peers for psychological safety, allowing them to grow and enhance their professional meaning.

Organizational Commitment: Accountability for Self and Peers

A number of this study's nurses said their preceptorship or mentorship experiences enhanced their sense of professional commitment. In their interviews, mental health, military, and emergency nurses state that their professional commitment is the result of the level of mastery they gained from their preceptorship or mentorship, allowing them to be accountable for themselves and their colleagues. Mental health nurses demonstrate a higher level of professional commitment by focusing entirely on the scope of their job rather than an organizational name. Similarly, military nurses execute their jobs because of the "oath" they took to practice their profession ethically after graduation and serve their country at whatever cost. Lastly, because they do not see themselves mentally doing anything else with their expertise, emergency nurses put their lives on the line to save the lives of others.

The mental health, military, and emergency nurses in this study exhibit a high level of professional commitment by emphasizing their expertise, swearing an oath to practice nursing ethically, and risking their lives to save citizen clients' lives, all of which are important for the future of the healthcare system. According to these nurses' interviews, such importance is founded on a single reason: delivering quality care to the public. Quality care begins with peer

support as well as public service. It extends to the individual nurse understanding their ethical responsibilities, having the essential abilities to care for themselves, sustaining a safe and supportive workplace for peers, and developing a commitment to excellence for themselves and peers to save citizen clients' lives (Randolph, 1988).

Saving lives is inextricably linked to these nurses' commitment to their peers and the accountability to support new nurses in efficiently navigating the beginning of their profession and becoming effective in quality care delivery. For this study's nurses, peer commitment is an interpersonal, social, emotional, and reflective moment. Emergency nurses, for example, believe that if skilled preceptors or mentors do not support them, they will "be in survival mode" while performing their duties. They also feel it is only fair to assist new nurses in developing the skills they need to avoid being in survival mode. In addition, military nurses strive to "pass on to others," particularly to their corpsmen, the positive experiences they had with their mentors and preceptors to foster a productive and supportive corporate culture. Similarly, mental health nurses, like others, believe they "could easily walk away from the entire healthcare system" if their peers did not exist. They believe the least they can do is provide new nurses the opportunity to feel encouraged and supported to give their best at work.

Because of their commitment to their peers and the level of experience and quality required for new nurses to be effective at their jobs, many of the nurses in this study felt that a lengthier, empowering, and mixed preceptorship and mentorship is required. This study's nurses similarly express that "preceptorship teaches you how to do a job, but mentorship teaches you how to live that job," especially emergency nurses. Both preceptorship and mentorship, according to mental health nurses, "build" them for success in their careers. Similarly, military nurses agree that an effective peer support program should provide new nurses with preceptors

and mentors while assisting experienced nurses with their daily struggles at work to have a quality and productive healthcare system.

Peer Support Narratives as Performative and Transformative

This study, guided by Pentland (1999), explores organizational narratives as influential changing mechanisms in organizational processes that challenge the status quo. In this regard, peer support narratives have the performative and transformative power, as well as the formative effect, to reorient healthcare organizations in the direction of retaining nurses and avoiding turnover.

The formative effect here refers to the potential of organizational policies to positively or negatively transform the future course of workplace policy development (Soss & Donald, 2014). Formative effects research has produced compelling explanations for the evolution of organizational policy in the healthcare system across time (Jacobs & Weaver, 2015). Formative effect research demonstrates that organizational policies can modify the healthcare organizational environment in such a way that nurses are not used as instruments but as valued assets that reshape the identities, understandings, interests, and preferences of nursing community actors (Soss & Donald, 2014). Peer support, for example, according to these nurses, not only increased the level of support among nurses or the level of their skills, but it also allowed the general public to recognize the value of nurses and gave them a seat at the healthcare table when they used these skills during the COVID-19 pandemic. As a result, they encourage healthcare institutions to develop a peer support program as a collective end that includes

preceptorship and mentorship for new and experienced nurses. I call this hybrid peer support because it includes both preceptorship and mentorship while also aiming to support both new and experienced nurses. However, realizing this collective end necessitates training, peer support programs, leadership, and persistent effort provided by healthcare organizations, which become more than just a means to an end but the day-to-day organizational embodiment of a collective end. That is, as organizations implement policies, they transform organizations and themselves (Cook, 2014). This process reinforces a tradition of formative effect scholarship's notion that a more dialogic relationship should exist between healthcare management and healthcare actors such as nurses for an effective healthcare system that retains and empowers its nurses.

Such a dialogic relationship should begin with the findings presented here of developing a peer program capable of altering routines, redistributing resources, and redefining culture, identity, and motivation in the healthcare system. In short, this study sought the perspectives of mental health, military, and emergency nurses on the impact of peer support on their professional meaning and organizational commitment. The nurses interviewed for this study report that they stay at their jobs because of their peers and the formal and informal peer support they provide to help them achieve emotional regulation, mastery, drive, psychological safety, and friendship to build a sense of belonging. These findings are consistent with previous research (Billings et al., 2021; Carvello et al., 2019; DeCicco, 2008; Harnish & Wild, 1994; Nisar & Maroulis, 2017).

According to DeCicco (2008), having preceptors and mentors in a peer support program benefits both new and experienced nurses, as well as the nursing profession and healthcare organizations. Based on her study, the following advantages of a hybrid approach in home health care nursing have been reported. First, it encourages preceptees and mentees to enter and continue professional integration to develop crucial clinical skills. Second, it empowers and

increases the competency of preceptors and mentors in providing better care to patients, resulting in job satisfaction. Finally, it allows healthcare organizations to profit from low nurse turnover and a high retention rate. For example, a preceptor stated that "new hires who feel supported are more likely to stay" (DeCicco, 2008, p. 28).

This hybrid peer support encourages us to let up on dichotomizing peer support. This form of peer support is advantageous because it fosters the needed rapport and relationship between peers that is required for SLBs' professional growth and decision-making (Lipsky, 2010). In fact, Harnish and Wild (1994) use a case study involving 2 nursing faculty as mentees and a mentor with 12 years of teaching experience to demonstrate that peer support is a deliberate approach that harnesses available internal resources, resulting in renewed commitment, increased dialogue, and more teamwork. Peer support is an important tool that healthcare administrators can use to introduce innovative human resource strategies that improve healthcare service delivery. Peer support is a key component of SLBs' professional identities, and undervaluing it can harm healthcare in general (Nisar & Maroulis, 2017). Peer support programs can give hospital administration insights into the nursing industry, allowing them to develop empowering strategies to retain nurses. Indeed, Billings et al. (2021) examine data from 28 mental health nurses during COVID-19 and claim that what helps frontline workers like nurses is, first and foremost, peer support. Accordingly, both preceptorship and mentorship as peer support are essential for these nurses to be competent at their jobs and successful in their careers. In this study, mental health, military, and emergency nurses all emphasize how transformative peer support was for their jobs and lives in their narratives.

A narrative inquiry into their lived experience has the added benefit of framing their story as a learning and professional development tool for the healthcare industry. A narrative inquiry

into these nurses' lived experiences offers a unique opportunity to capture and document the rich and diverse stories of their professional journeys. For example, centering nurses' narratives allows this study to share a deep exploration of the challenges, triumphs, and personal growth they encounter throughout their careers. Such exploration provides a platform for nurses to share their insights, lessons learned, and best practices with colleagues and healthcare leaders. Furthermore, narratives have the power to humanize the healthcare experience and foster empathy and understanding among healthcare professionals, policymakers, and the public. By sharing their stories, nurses can shed light on the realities of frontline healthcare delivery, including the emotional toll and systemic challenges they face. These narratives help stakeholders appreciate the complexities of nursing practice and nurses' invaluable contributions to patient care and outcomes. By framing this study's nurses' stories as learning tools, nurses can contribute to a culture of continuous learning and professional development within the healthcare industry.

Professional development aims to improve practice by changing one's thinking about one's work. Schön (1987) emphasizes not just the development of critical reflecting capacity in learners but also the application of praxis-based experiential learning or reflection-in-action to achieve real-world improvements. Though reflection-in-action is essential for these nurses to pass down knowledge to new nurses and support seasoned ones, it does not ensure consistency in the hybrid peer support learning model because such a personalized model is subject to a plethora of variables, including individuals' motivation to learn, the level of connection between peers, the level of interaction, and the ideal condition for dialogue.

Healthcare administrators might use a formal element to attain the required learning and support goals. Because hybrid peer support combines preceptorship or formal peer support with

mentoring or informal peer support, they can establish formal performance metrics to assess program participants. In this way, leadership would shape the length of the program, provide resources, and create an empowering environment to support the program and participants. Similarly, many nurses in this study believe that an effective peer support program should have characteristics that empower its participants, both new and experienced nurses. In this study, they show that a combination of ephemeral preceptorship and continuous mentorship or hybrid peer support is critical in allowing nurses to access knowledge, interact to create agency, construct identities to belong, develop and commit to a career path, and adapt to changing personal, environmental, and professional roles.

Conclusion

This chapter reflects the more extensive narrative using the common themes — professional meaning and organizational commitment — and sub-themes seen in the narratives of this study's mental health, military, and emergency nurses about their peer support experiences. This chapter shows that nurses engage with one another to develop professional meaning and organizational commitment through peer support. First, this process starts with co-supporting quality care. Co-supporting quality care through nursing peer support holds significant importance in fostering a culture of collaboration, learning, and excellence within healthcare settings. Peer support among nurses provides a valuable avenue for sharing knowledge, expertise, and best practices, thereby enhancing the quality and safety of patient care. By engaging in peer learning and knowledge sharing, this study's nurses leverage their

collective experience and insights to address clinical challenges, optimize care delivery processes, and improve patient outcomes.

Second, the narratives of this study's nurses are performative in nature, reflecting their identities, roles, and interactions within healthcare settings. Through storytelling, the nurses of this study construct and negotiate their professional identities, drawing on their experiences, values, and beliefs to define their roles within the healthcare team. By sharing their stories with peers, this study's nurses not only affirm their professional identities but also assert their agency or autonomy as frontline healthcare providers, thereby shaping the collective performance of nursing practice.

Third, the peer support narratives presented in this study have the potential to bring about transformative change within nursing practice and organizational culture. These narratives about peer support foster a sense of empowerment and agency among this study's nurses, motivating them to engage in quality care delivery actively. Such narratives can create opportunities for dialogue, reflection, and collective sensemaking, encouraging nurses to examine their practices critically and embrace new ways of thinking and delivering care. As demonstrated by the voices and experiences of the nurses in this study, peer support contributes to a culture of openness, support, safety, learning, and development within healthcare organizations, which can drive positive transformational change at both the individual and systemic levels.

Finally, both formal and informal peer support — preceptorship and mentorship — play instrumental roles in encouraging nurses to be accountable to themselves and their peers. Through preceptorship and mentorship programs, this study's nurses develop a strong sense of personal accountability for their actions and decisions. Also, the stories of the nurses in this

study demonstrate how preceptors and mentors provide guidance, feedback, and support to help them navigate their roles effectively and uphold professional standards of practice. By setting clear expectations, providing constructive feedback, and holding nurses accountable for their performance, preceptors, and mentors empower nurses to take ownership of their professional development and strive for excellence in patient care delivery. Moreover, as this study's nurses progress in their careers, they are inspired to pay forward the support and guidance they received from their own preceptors and mentors, thereby perpetuating a cycle of accountability and mentorship within the nursing profession. This reciprocal exchange of knowledge and support strengthens nurses' accountability to themselves and their peers, fostering a culture of continuous learning, growth, and professional excellence within nursing.

CHAPTER SIX: CONCLUSIONS AND IMPLICATIONS

Introduction

This chapter summarizes the main themes and narratives uncovered throughout this study. This chapter also provides a cohesive and comprehensive overview of the research findings. This chapter further expands on the broader significance and implications of this study's findings for nursing practice, professional development, and policy, highlighting the critical role of peer support in developing and nurturing the psychological drivers — autonomy, mastery, purposefulness — and social drivers — supportive workplace, sense of belonging, and psychological safety. By identifying the factors that facilitate or hinder effective peer support among nurses, this study proposes a new peer support conceptual model that can inform the development of tailored interventions that promote a culture of collaboration, mutual support, and learning within nursing teams. Lastly, this chapter discusses how this study may contribute to the advancement of nursing research and public administration methodologies, particularly in the realm of narrative inquiry, by demonstrating the value of narrative approaches for exploring complex and nuanced aspects of nursing practice and SLBs' peer support.

This chapter is organized to revisit the stories of mental health, military, and emergency nurses to support my conclusions. In addition, I lay the groundwork for future research for narrative inquiry, such as new lines of inquiry into peer support and its impact on professional meaning and organizational commitment.

Summary of the Study

This study aimed to look closely and gain a better understanding of the effect of formal peer support or preceptorship and informal peer support or mentorship on the professional meaning and organizational commitment of military, mental health, and emergency nurses. While numerous studies examine peer support practices in nursing, I found no narrative inquiries of how nurses find meaning in their job and commitment to their profession and peers through their peer support experiences in the context of their everyday clinical practices. By re-narrating their stories, I intend to expand our contextualized understanding of the effect of peer support in a professional occupation and the personal lives of three different types of nurses whose clinical settings were suited for such research.

In brief, I went over research traditions relevant to the conceptual foundations of nursing peer support on the frontline, including street-level bureaucrat theory, institutional logics, intrinsic motivation, organizational socialization, professional meaning, and organizational commitment. In my discussion section, I was guided by Pentland's (1990) approach in re-narrating the organizational lived experiences of my participants. I added other scholars' theoretical assumptions and findings that contribute to the increasing body of peer support literature as a performative and transforming experience. These scholars' descriptions of peer support as a mechanism for positively transforming nurses' careers and environments provided the framework for me to highlight how the impact of formal and informal peer support intersected with their descriptions of peer support transformation in military, mental health, and emergency nurse narratives.

I chose narrative inquiry as my method for exploring the influence of peer support on the frontlines because my inquiry was founded on the notion of performed narratives, which are stories that are acted on in actively affecting the present moments. In this sense, performed narratives play a vital part in clinical treatment by not only conveying what happens during peer interactions but also how that encounter serves as a chapter in a bigger narrative of support to saving people's lives. Many studies, as cited in my methodology section, have employed narrative inquiry to reflect the accounts of frontline or street-level bureaucrats in various situations. The majority of these studies look at what the researcher saw as established cultural norms as well as institutional and policy practices of frontline workers. What I found lacking was research that simply interviewed frontline workers about their experiences with peer support and how it affected their jobs over time. Maynard-Moody and Musheno (2022), for example, studied the experiences of cops, teachers, and counselors and discovered differences between participants' beliefs in their stories and policy scholars' assumptions regarding autonomy versus discretion and state-agent narrative versus citizen-agent narrative. Because of these differences, they argue that SLBs share pragmatic improvisation and reproduction, embedded cultural norms, and institutional practices that shape their professional identities. These findings emphasize the importance of an institutional logics approach in an organizational setting. However, we still need to figure out how to combine the concept of embedded institutions with a conversation about peer support, which influences the quality of frontline workers.

As previously stated, I recruited 21 volunteers who work as military, mental health, and emergency nurses in public hospitals. Their nursing profession provided formal (preceptorship) or informal (mentorship) peer support that influenced their lives, jobs, and careers. I began my research with a critical question: *How does peer support affect nurses' cultivation of professional*

meaning and organizational commitment in different work settings? The data was then collected through 21 semi-structured interviews conducted via Zoom. Listening to the participants' interviews several times, cleaning, re-reading, creating notes, and applying Braun and Clarke's (2019) reflexive thematic coding to the transcripts in Delve led me to my conclusions. I identified two main themes with several sub-themes in the lived experiences of military, mental health, and emergency nurses: professional meaning and organizational commitment. These themes were framed using the time, social, and place narrative inquiry (Connelly & Clandinin, 2006).

Following my conclusions and recommendations for future research, I revisit below military, mental health, and emergency nurses' narratives about peer support and its effect through the two identified themes in my findings.

Substantive Point A: Mental Health Nurses Narratives Revisited

"I think both formal and informal mentorship helped to build me."

Prior to peer support, most mental health nurses in their first years of nursing could not wholly participate in various mental assessments of patients and instead shadowed the work of experienced mental health nurses due to their mastery and competency level. After experiencing peer support — preceptorship or mentorship — the mental health nurses saw changes in how they see themselves, their careers, and their peers due to peer support. The narratives of mental health nurses highlight the impact of peer support on their lives, jobs, and careers as they develop professional meaning and commitment. These nurses express a genuine interest in nursing early

in their lives. However, peer support strengthens that interest by allowing them to develop their professional identity, professional purpose, job motivation, autonomy, and a sense of belonging. This development helps them not only to avoid the "daunting" period of nursing but also to "build" them with effective skills for a brighter future.

Moreover, most of these nurses concluded their interviews by emphasizing the importance of peer support in fostering an environment of learning, interaction, development, and adapting components for all nurses' successful careers. In this sense, they are committed to their profession, not "a logo," and to developing a workplace with such components to help new and experienced nurses succeed because they would "easily walk away from the entire healthcare system" if they did not have peers.

Substantive Point B: Military Nurses Narratives Revisited

"We just want to be treated with the same respect that we give our patients."

Military nurses joined the army, marines, or navy for the esprit de corps and camaraderie before they had formal or informal peer support. They understood they were officers first and nurses second because they wanted to serve their country and save other service members' lives. However, in their stories, it was their mentors and preceptors who prepared them, not academic nursing foundations. These nurses obtained structured training for deployment and critical care services throughout their formal or informal peer support to develop professional meaning through mastery, leadership, a sense of belonging, and emotional regulation. Such emotional regulation is critical because they create relationships with peers and their mentors or

preceptors, which define their learning processes as well as their short- and long-term career success.

Such emotional relationships, such as those with mentors or preceptors, are crucial in military nursing since the positive or negative experiences they carry from them will shape the following many years of their career. If they had a bad relationship with their mentors or preceptors, they might not last as long at their job due to early burnout. They added that establishing a therapeutic relationship with the person from whom they are learning is necessary for them to talk about all of the seen war zone calamities and to take care of themselves before they can effectively care for patients. In this way, these nurses bond traumatically by sharing difficult experiences. Knowing how important it is for their mentors and preceptors to be able to regulate their emotions and have the necessary skills to be successful in their jobs, these nurses believe that a peer support program should be established to value military nurses, empower them, and treat them with "the same respect" that they treat their patients.

Substantive Point C: Emergency Nurses Narratives Revisited

"I would love to be patient and nurturing and help [new nurses] to not be afraid to ask me questions because I would love to support someone in that [positive] setting."

Most emergency nurses were unfamiliar with all the clinical procedures in an emergency room before getting formal or informal peer support. Even if these nurses have previously worked as other types of nurses, they undergo considerable on-the-job preceptorship or mentoring when they become emergency nurses because what they do is only completely

learnable through practice. These nurses encounter peer support at the frontlines on their first work day. The majority of them thought that peer support gave them professional meaning by fostering professional identity, mastery, and psychological safety. Feeling safe allows emergency nurses to grow professionally, engage in formal and informal relationships with peers, and enjoy their jobs in a supportive and positive workplace atmosphere.

In this encouraging and positive environment, these nurses learned everything they needed to know about emergency care from their preceptors or mentors throughout "6 to 8 weeks" of formal and indeterminate informal trauma, pediatrics, gunshot wounds, stabbings, and disaster training. During this training, their support and relationship with their preceptors or mentors impact how they regard their relationships with their peers. For example, having an effective and supportive preceptor or mentor could make their career and leave them "more interested in passing on those skills" as a "team player." In this sense, emergency nurses are also willing to share their positive experiences from which they learned how to excel at their job by "nurturing" new and experienced nurses to have psychological safety and practical skills to deliver quality emergency treatment.

Substantive Point D: Common Themes Revisited

Peer support becomes a buffering mechanism in the narratives of this study's military, mental health, and emergency nurses, either protecting them from potentially negative outcomes of traumatic clinical events or changing how they respond to them. Peer support as a coping mechanism changes these nurses' cognitive and behavioral attitudes toward managing

internal and external clinical demands. This coping process includes problem-solving, leadership, emotional regulation, and trauma bonding for military nurses. Similarly, peer support leads to "working in the trenches" together to bond traumatically, building problem-solving and teamwork skills. Finally, peer support allows emergency nurses, like military and mental health nurses, to master their stress and skills to provide quality critical care.

These nurses' narratives extend to demonstrate the importance of incorporating both preceptorship and mentorship into a peer support program that empowers both new and experienced nurses. I refer to this as hybrid peer support. In their opinion, this hybrid peer support is vital for two reasons. First, for new nurses, the hybrid peer support framework emphasizes empowerment, identity development, and role competence development. Second, it enables experienced nurses to communicate with peers to provide and receive feedback on their growth, emotional regulation, and recognition. According to these nurses, recognition is powerful because they want to feel "respected and valued" to not only have a seat at the healthcare table but also to revolutionize the care delivery process.

Hybrid peer support then is a two-sided tool. On the one hand, it is about demonstrating one's expertise and collaborating with others to create a supportive environment. On the other hand, it is an invitation to assist others, give others a voice, exchange ideas, create psychological safety, and work with others to build an environment of meaning, relationships, recognized performances, commitment, and retention.

Conclusions – What Are the Narratives Telling Us?

Although the street-level bureaucrat and nursing literature typically take professional meaning and organizational commitment in a competent and supportive healthcare environment as granted, this study does not. Rather, this study questions how professional meaning and organizational commitment emerge using the peer support framework. That quest is critical because a supportive and competent environment enables nurses to deal with daily work uncertainties, provide effective care services, and motivate them to stay at their jobs.

My first conclusion from this study is that the stories from mental health, military, and emergency nurses describe peer support experiences that had a positive impact on their jobs, lives, professional meaning, and commitment, as evidenced by their successful careers due to preceptorship or mentorship, their choice to support peers and improve their new nursing experience with hybrid peer support and exercise teamwork approaches for a supportive and productive work environment. Hybrid peer support for this study's nurses combines preceptorship and mentorship programs to support both new and experienced nurses. For new nurses, a hybrid peer support program offers hands-on formal training and clinical skill development, as well as informal mentoring from leaders to help them transition into their jobs and adapt to the demands of their careers. For experienced nurses, hybrid peer support sharpens their interpersonal, coaching, and leadership skills. This skill development helps experienced nurses see that supporting and guiding new nurses through their professional path is fulfilling since they positively impact their peers' lives and careers.

My second conclusion is that peer support created transformative experiences for mental health, military, and emergency nurses. These transforming experiences are demonstrated by their new ways of thinking and doing their job with the necessary skills, seeing themselves in relation to peers, and understanding how important it is for nurses to take care of themselves

before they can effectively deliver care. This process is further demonstrated by the skills they have gained, as well as their ability to think and act in extremely demanding clinical settings to create opportunities for their own mentees and preceptors not to burn out too quickly, as well as emotionally supporting their distressed peers. For example, peer support programs offer a crucial lifeline for nurses dealing with the unique challenges and emotional demands of caring in this study. In mental health nursing, military nursing, and emergency nursing, where nurses often encounter high-stress situations and traumatic events, peer support initiatives contribute to the well-being and resilience of frontline healthcare workers. Peer support efforts provide the nurses of this study with a supportive network of peers who understand the unique demands of their profession. Such supportive peer networks promote a culture of mutual emotional support, learning, and growth, empowering nurses to develop the skills, confidence, and resilience needed to thrive in their roles and make meaningful contributions to patient care, the nursing profession, and the healthcare system.

Finally, based on the stories of this study's nurses, my third conclusion is that hybrid peer support can positively impact the healthcare system by creating and recreating the conditions required for new and experienced nurses to feel supported to thrive at their jobs. Even with fewer resources and staff, the collaboration and teamwork offered by hybrid peer support increase nurses' ability to cope with work difficulties and provide quality care to their patients. Though a toxic environment can diminish the value of hybrid peer support, it remains an effective coping mechanism for new or experienced nurses to use in gaining control over how they perceive their competency, learning, practicing of skills, profession, commitment, and care strategies to achieve positive patient outcomes. Furthermore, according to interviews with this study's nurses, this hybrid peer support fosters a supportive and integrative workplace that is built on structural (i.e.,

close peers) and functional (i.e., socio-emotional) support from peers and organizational leaders, resulting in a culture of collective learning, guiding, and practice. As a result, this collectivity increases job engagement and efficacy for both new and experienced nurses, allowing them to establish a cyclical culture of support, collaboration, learning, and growth within the healthcare system.

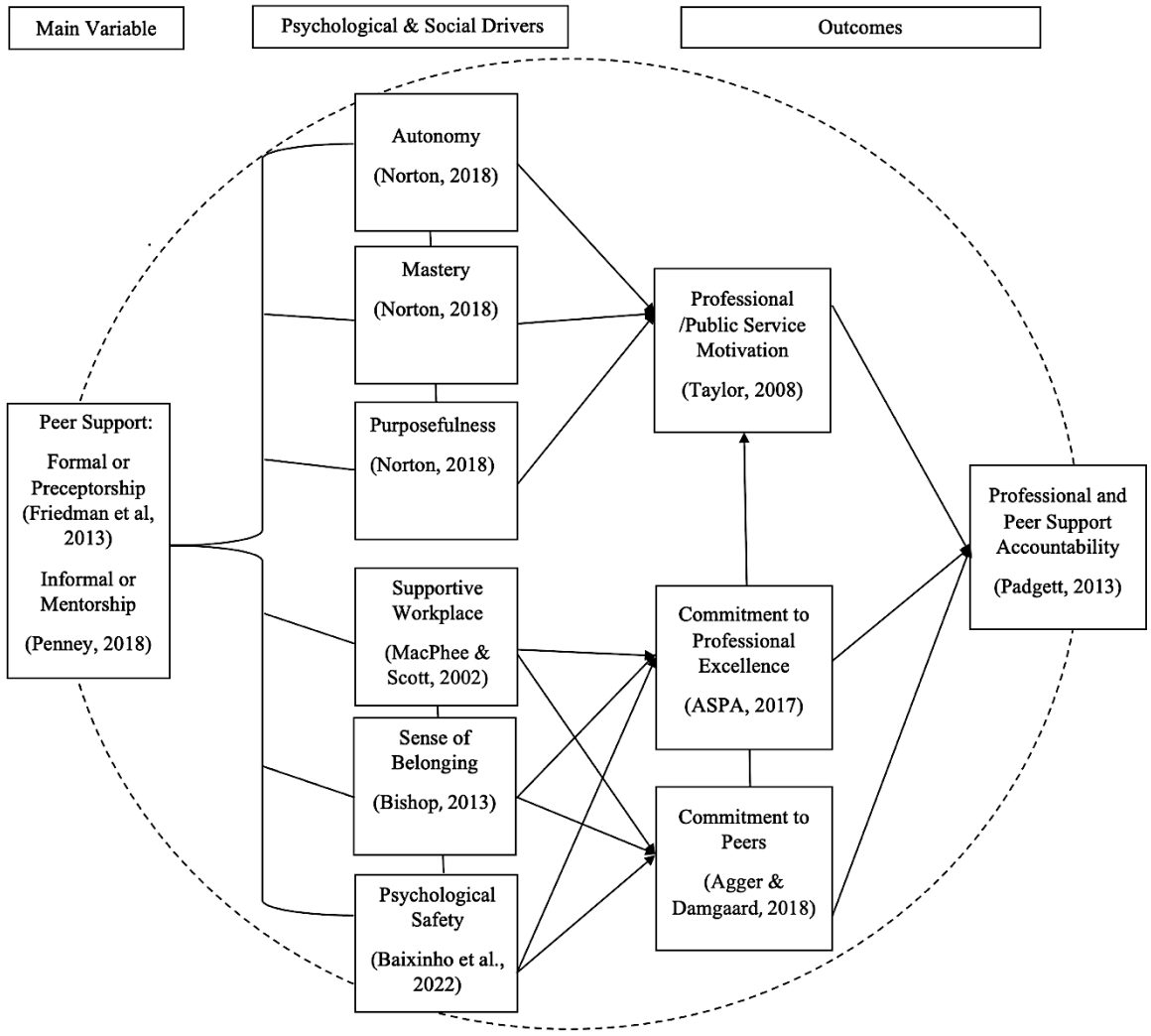
This hybrid peer support model expands the peer support conceptual model on which this study is based, as seen in **Figure 1**. This figure illustrates how peer support acts as a force multiplier in engaging nurses in intrinsic motivators or psychological drivers such as autonomy, mastery, and purpose (Norton, 2018). These factors then help bond nurses through shared professional values and clinical traumas, instilling a shared responsibility for an organizational culture that nurtures new nurses while empowering experienced nurses (Tanaka et al., 2016). Such a positive culture, therefore, creates a culture of rekindled passion for the profession and professional accountability in nursing, which is the accountability of caring for oneself and one's peers to provide productive and effective care (Padgett, 2013).

Providing effective care in this hybrid peer support model is also dependent on nurses' sociological (e.g., social identity, motives, attitudes) and organizational institutionalism (e.g., organizational values, norms) identities, which lead to embedded social drivers such as supportive workplace, sense of belonging, and psychological safety. Nurses' supportive and integrative workplace is built on structural (i.e., close peers) and functional (i.e., socio-emotional) supports that necessitate peer social support as well as a collective process of learning, guiding, and practicing that leads to increased work engagement and efficacy (MacPhee & Scott, 2002). Similarly, Antoinette Bargagliotti (2012) and Bishop (2013) argue that nurses' work engagement enables them to be committed to their profession while emotionally attached

to their peers, implying that work engagement is a crucial antecedent to nurses' sense of belonging. Belongingness is essential for nurses' self-esteem and psychological safety because it allows them to connect with peers at various interpersonal levels, making them feel seen, heard, and valued (Baixinho et al., 2022). Having such a feeling of belonging is integral for nurses because it makes them feel accepted and respected as a person and a professional, which is essential to how nurses describe the quality of their work settings, their commitment and accountability to their profession and peers, and the quality of care they deliver.

Indeed, one of the most important characteristics of being an SLB or nurse, according to the American Society for Public Administration's (2017, p. 4) Code of Ethics and Agger and Damgaard (2018), is to interactively and cyclically provide care on the frontlines with a commitment to support peers understand public sector logics and commitment to professional excellence in advancing the public interest of saving lives. This process, together with the description of the above hybrid peer support, resulted in a revised peer support conceptual model. (see **Figure 6** below).

Figure 6: Revisited Peer Support Conceptual Model



Positive relationship
Positive cyclical process
Positive interaction

Research Limitations

In public administration research, particularly in social science, sampling aims to draw trustworthy and relatively accurate conclusions about a wider population (Gobo, 2004; Groeneveld et al., 2015). In other words, the sampling approach used in research should be as representative as possible of the population being studied. As a result, many qualitative public administration researchers, particularly those who collect data through interviews and undertake narrative analysis, have relied heavily on purposive sampling approaches to base their findings (Clandinin & Connelly, 2006; Dodge, Ospina & Foldy, 2005; Maynard-Moody & Musheno, 2003).

This study used purposive sampling to choose 21 licensed experts who can give extensive and meaningful information regarding the impact of nurses' peer support (Thorne, 2008). Although this sample strategy dominates narrative inquiry scholarship in creating social patterns, questions of researchers and selection biases have arisen (Etikan, Musa & Alkassim, 2016; Sharma, 2017). As a result, this study has a few limitations. First, while purposive sampling is necessary for this study's objective, participant selection was not random, which might be a source of bias. Randomly selecting participants for a more extensive study may help reduce researcher bias by providing a more varied and impartial sample. Miller (2000), for example, randomly selected 200 participants to investigate the media's role in depicting threats to society, with an emphasis on how environmental realities are produced from both objectivist and subjective viewpoints. The most essential takeaway from this work is that random sampling can be useful in qualitative research.

Second, this study's findings do not document the behaviors and actions of all SLBs, but rather the individual actions of this study's 21 mental health, military, and emergency nurses about the impact of peer support on their professional meaning (why they feel competent and love their job) and organizational commitment (why they want to stay at work). Although the goal of a narrative inquiry is not generalizability (Lessard et al., 2015), this process may raise objectivity concerns because each SLB acts uniquely based on their occupation, experience, and abilities (Maynard-Moody & Musheno, 2003). In other words, because this study's nurses all act differently, this study contextualizes peer support to provide more understanding and richness to scholarship to scholarship. In this regard, exploring the impact of organizational structure on peer support in changing the care delivery process can be another valuable research.
Such research can compare public and private organizations with more or less hierarchical cultures to determine how consumer-run or nonprofit public hospital structures impact peer support implementation and nurses' care delivery processes.

Third, though the stories of this study were constructed by male and female nurses of different races, different nursing backgrounds, different years of experience, and typical educational levels is important, their stories remain fluid. While they share stories that reflect the current learning context as a result of the transformative power of peer support, their interpretations of their experiences may change over time. Also, in narrative inquiry, story interpretation is fluid too and may not be final since it is only one researcher's perspective among many (Jha, 2018). Given the fluidity with which narratives are recounted and interpreted, a more objective and longitudinal study of this study's participants' experiences could make a stronger case for peer support transforming power. For example, Bullough and Baughman (1996)

use a nine-year longitudinal case study to provide insight into the impact of narrative reasoning on teacher development. Longitudinally studying individuals' stories allows researchers to get objective insights into change, development, and resilience processes that influence people's lived experiences.

Implications for Future Research

As expected from any story, my research stories suggest many untold stories to follow. Narratives from the military, mental health, and emergency nurses about how peer support in an individualized framework has transformed their professional and personal lives, the roles they play in the professional and personal lives of their peers, and the mentors or preceptors they want to be in supportive and productive clinical settings. The idea that these nurses believe peer support contributes to their career success regarding how they view their developed and valued selves and peers in their clinical settings is intriguing and important. However, no study, even mine, can guarantee that what I found with these participants will be the same for other nurses working in similar clinical occupations and situations.

More longitudinal or mixed-method research on the perception of the effect of peer support on participants' professional meaning, organizational commitment, and lives may assist in identifying nuances and how layers of peer support impact nurses. These impacts may shape nurses' professional identity, motivation to work or stay at work, commitment to their peers or profession/organization, psychological safety, and sense of belonging. The findings of such research can then help healthcare administrators shape how they train new nurses to be effective

while retaining experienced nurses. Moreover, further exploration into the idea that peer support practices are transformational for nurses may assist healthcare administrators in gaining a new perspective on what transformative peer support power means to nurses, health administrators, and the healthcare system.

The lived experiences of military, mental health, and emergency nurses raise questions about what hybrid peer support is. Is this type of peer support more transformative than formal or informal peer support alone, and what are the implications for healthcare administrators? Can anybody be a peer supporter? Or are some people naturally better at it? Or is there a possible impact of nurses' varying educational backgrounds, titles, and certifications (e.g., BSN, RN, nurse practitioner…) on interpersonal relationships, unit cultures, and peer support? This line of inquiry leads to a broader context for further exploration of participants' stories of peer support and its impact. For example, examining the impact of peer support on healthcare administrators or peer support practices of nurses with different educational backgrounds could provide valuable insights into our understanding of peer support.

Finally, there is a benefit in carefully considering the likelihood that a process for improving healthcare practice will genuinely enhance people's lives. This study raises the possibility of groundbreaking peer support research for informing both scholars and practitioners about the implications of peer support in the public service workplace. Both policymakers and healthcare managers can then recognize the importance of peer support and the formation of professional identity and skills, a supportive and competent environment, and commitment to quality care in saving lives. In other words, can an effective peer support program save more patients' lives? This question not only motivates my work and scholarly objectives but also helps develop a peer support framework containing elements with beneficial correlations that I hope

can help further public administration scholarship. It is also my hope that this research will spark a more considerable discussion in the fields of healthcare and public administration that will go beyond what we aim to accomplish as public administration scholars and into making a genuine difference in the lives of those we encounter.

References

Abbott, A. (1992). From causes to events: Notes on narrative positivism. Sociological Methods and Research 20:428–55

Agger, A., & Damgaard, B. (2018). Interactive policy processes: A challenge for street-level bureaucrats. *Scandinavian Journal of Public Administration*, *22*(3), 89-108.

Allen, N. J. and Meyer, J. P. (1996). Affective, continuance and normative commitment to the organization: An examination of construct validity. Journal of Vocational Behavior, 49, 252-276.

Allen, N. J. and Meyer, J. P. (1990). the measurement and antecedents of affective, continuance and normative commitment to the organization. Journal of Occupational & Organizational Psychology,
6(1), 1-17.

Allevato, E. (2020). Organizational culture change: Growth mindset, positive psychology, and empowerment. In Social entrepreneurship and corporate social responsibility (pp. 439-454). Springer, Cham.

Alhonsuo, M., Sarantou, M., & Miettinen, S. (2022). Digital Storytelling to Share Service Experiences and Find Insights into Health Care. In Service Design Practices for Healthcare Innovation (pp. 529-547). Springer, Cham.

American Nurses Association. (2015). Code of Ethics for Nurses with Interpretive Statements. American Nurses Association: Silver Springs, MD.

American Society for Public Administration. (2017). American Society for Public Administration Code of Ethics. *Public Administration Review,* p. 810.

Antoinette Bargagliotti, L. (2012). Work engagement in nursing: a concept analysis. *Journal of advanced nursing*, *68*(6), 1414-1428.

Aparício, C., & Nicholson, J. (2020). Do preceptorship and clinical supervision programmes support the retention of nurses?. British Journal of Nursing, 29(20), 1192-1197.

Armitage, P., & Burnard, P. (1991). Mentors or preceptors? Narrowing the theory-practice gap. Nurse Education Today, 11(3), 225-229.

Auger, P., & Woodman, R. W. (2016). Creativity and intrinsic motivation: Exploring a complex relationship. The journal of applied behavioral science, 52(3), 342-366.

Azeem, S. M., & Akhtar, N. (2014). Job satisfaction and organizational commitment among public sector employees in Saudi Arabia. International Journal of Business and Social Science, 5(7).

Bae, S.H. (2011). Organizational socialization of international nurses in the New York metropolitan area. *International Nursing Review* 59, 81–87

Baixinho, C. L., Ferreira, Ó. R., Medeiros, M., & Oliveira, E. S. F. (2022). Sense of belonging and evidence learning: A focus group study. *Sustainability*, *14*(10), 5793.

Berg, L. N., & Pinheiro, R. (2016). Handling different institutional logics in the public sector: Comparing management in Norwegian universities and hospitals. In *Towards a comparative institutionalism: Forms, dynamics and logics across the organizational fields of health care and higher education* (pp. 145-168). Emerald Group Publishing Limited.

Billings, J., Biggs, C., Ching, B. C. F., Gkofa, V., Singleton, D., Bloomfield, M., & Greene, T. (2021). Experiences of mental health professionals supporting front-line health and social care workers during COVID-19: qualitative study. BJPsych open, 7(2), e70.

Bishop, M. (2013). Work engagement of older registered nurses: the impact of a caring-based intervention. *Journal of nursing management*, *21*(7), 941-949.

Sharma, G. (2017). Pros and cons of different sampling techniques. *International journal of applied research*, *3*(7), 749-752.

Miller, D. (2000). A Note on the Representation of Environmental Risks in the News. *The Qualitative Report*, *4*(1/2).

Bonner, A. J. (2001). Producing the magnum opus: The acquisition and exercise of nephrology nursing expertise.

Boykin, A., & Schoenhofer, S. O. (2001). Nursing as Caring: A Model for Transforming Practice. Boston, MA: Jones and Bartlett Publishers.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. Qualitative research in sport, exercise and health, 11(4), 589-597.

Bredenkamp, D., Dull, M., LaRiviere, L., & Sogodogo, A. (2022). Frontline Service Narratives and Workplace Identities in Behavioral Health and Developmental Services [Paper Presentation]. American University DC Public Management Consortium 2022: Washington, DC, United States.

Brehm, J. O., & Gates, S. (1999). Working, shirking, and sabotage: Bureaucratic response to a democratic public. University of Michigan Press.

Brenne, B. A., Hedlund, M., & Ingstad, K. (2023). Nurses' professional discretion in the purchaser-provider split in home care in Norway. *Journal of Advanced Nursing*.

Brodkin, E. Z. (2011). Policy work: Street-level organizations under new managerialism. Journal of Public Administration Research and Theory, 21(suppl_2), i253-i277.

Brotheridge, C. M., & Lee, R. T. (2003). Development and validation of the emotional labour scale. *Journal of Occupational and Organizational Psychology*, *76*(3), 365-379.

Brown, A. D., & Thompson, E. R. (2013). A narrative approach to strategy-as-practice. Business History, 55(7), 1143-1167.

Bryman, A. (2004). Social Research Methods (2nd ed). Oxford: Oxford University Press.

Bullough Jr, R. V., & Baughman, K. (1996). Narrative reasoning and teacher development: a longitudinal study. *Curriculum inquiry*, *26*(4), 385-415.

Buffat, A., Hill, M., & Hupe, P. (Eds.). (2015). *Understanding street-level bureaucracy*. Policy Press.

Burke, L. M. (1994). Preceptorship and post-registration nurse education. Nurse Education Today, 14 (1), 60-66

Canadian Nurses Association. (2004). Achieving excellence in professional practice: A guide to preceptorship and mentoring. Retrieved from http://www.cna-nurses.ca/CNA/documents/pdf/publications/Achieving_Excellence_2004_e.pdf.

Carbone, R., Ferrari, S., Callegarin, S., Casotti, F., Turina, L., Artioli, G., & Bonacaro, A. (2022). Peer support between healthcare workers in hospital and out-of-hospital settings: a scoping review. Acta Bio Medica: Atenei Parmensis, 93(5).

Carvello, M., Zanotti, F., Rubbi, I., Bacchetti, S., Artioli, G., & Bonacaro, A. (2019). Peer-support: a coping strategy for nurses working at the Emergency Ambulance Service. Acta Bio Medica: Atenei Parmensis, 90(Suppl 11), 29.

Clandinin, D. J., Cave, M. T., & Berendonk, C. (2017). Narrative inquiry: a relational research methodology for medical education. *Medical education*, *51*(1).

Clandinin, D.J., & Connelly, M. (2004). Knowledge, narrative and self-study. In *International handbook of self-study of teaching and teacher education practices* (pp. 575-600). Dordrecht: Springer Netherlands.

Clandinin, D. J., & Connelly, F. M. (2000). Narrative Inquiry: Experience and Story in Qualitative Research. San Francisco: Jossey-Bass.

Clandinin, D. J., Pushor, D., & Orr, A. M. (2007). Navigating sites for narrative inquiry. Journal of Teacher Education, 58(1), 21–35.

Cohen, C., Jones, K. B., & Tronto, J. C. (1997). Women transforming politics: An alternative reader. New York: New York University Press.

Cohen, G., & Cohen, N. (2023). Understanding street-level bureaucrats' informal collaboration: Evidence from police officers across the jurisdictional divide. *Public Management Review*, *25*(2), 224-242.

Cohen, N., & Golan-Nadir, N. (2020). Why do street-level bureaucrats risk themselves for others? the case of Israeli police officers. Australian Journal of Public Administration, 79(4), 480–494.

Cohen, N. (2018). How culture affects street-level bureaucrats' bending the rules in the context of informal payments for health care: The Israeli case. *The American review of public administration*, *48*(2), 175-187.

Cohen, S., Gottlieb, B., Underwood, L.G. (2000). Social relationships and health. In: Cohen, S., Underwood, L.G., Gottlieb, B. (Eds.), Social Support Measurement and Intervention: A Guide for Health and Social Scientists. Oxford University Press, Toronto, pp. 3pp

Cook, B. J. (2014). Bureaucracy & Self-Government-Reconsidering the role of Public.
Administration in American Politics. Second Edition. Baltimore, Maryland: Johns Hopkins University Press.

Cottingham, S., DiBartolo, M. C., Battistoni, S., & Brown, T. (2011). Partners in nursing: A mentoring initiative to enhance nurse retention. Nursing Education Perspectives, 32(4), 250-255.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. Theory into practice, 39(3), 124-130.

Cricco-Lizza, R. (2014). The need to nurse the nurse: Emotional labor in neonatal intensive care. *Qualitative Health Research*, *24*(5), 615-628.

Currie, W. L., & Guah, M. W. (2007). Conflicting institutional logics: a national programme for IT in the organisational field of healthcare. *Journal of Information Technology*, *22*, 235-247.

Davidhizar, R., & Lonser, G. (2003). Storytelling as a teaching technique. Nurse Educator, 28(5), 217-221.

Deci, I. E. L. (1971). Effects of externally mediated rewards on intrinsic motivation. *Journal of Personality and Social Psychology*, 18, 105-115.

DeCicco, J. (2008). Developing a preceptorship/mentorship model for home health care nurses. *Journal of Community Health Nursing*, 25(1), 15-25.

Dennis, C. L. (2003). Peer support within a health care context: a concept analysis. International journal of nursing studies, 40(3), 321-332.

Destler, K. N. (2017). A matter of trust: Street level bureaucrats, organizational climate and performance management reform. *Journal of Public Administration Research and Theory*, *27*(3), 517-534.

Dodge, J., Ospina, S. M., & Foldy, E. G. (2005). Integrating rigor and relevance in public administration scholarship: The contribution of narrative inquiry. Public administration review, 65(3), 286-300.

Donchin, A. (2000). Autonomy, interdependence, and assisted suicide: respecting boundaries/crossing lines. *Bioethics*, 14(3), 187-204.

Doring, C., & Carty, R. (2021). Impact of Public Service Logic to Improve Serviceness in the Public Sector. *Journal of Positive School Psychology*, *5*(3), 59-70.

Drumm, M. (2013). The role of personal storytelling in practice. Glasgow, UK: Institute for Research and Innovation in Social Services.

Edward, K. L., Ousey, K., Playle, J., & Giandinoto, J. A. (2017). Are new nurses work ready–the impact of preceptorship. An integrative systematic review. *Journal of professional nursing*, *33*(5), 326-333.

Eisen, M. J. (2001). Peer-based professional development viewed through the lens of transformative learning. Holistic nursing practice, 16(1), 30-42.

Eisenberger, R., Fasolo, P. and Davis La Mastro. (1990). Perceived organizational support and employee diligence, commitment and innovation. Journal of Applied Psychology, 75(1), 51-59.

Erickson, R. J., & Grove, W. J. (2008). Emotional labor and health care. Sociology Compass, 2(2), 704-733.

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American journal of theoretical and applied statistics*, *5*(1), 1-4.

Feldman, M.S., Brown, R.N., & Horner, D. (2004). Making sense of stories: rhetorical approach to narrative analysis. Journal of Public Administration Research and Theory: JPART 14 (2), 147–170.

Ferreira, F. D. C., Dantas, F. D. C., & Valente, G. S. C. (2018). Nurses' knowledge and competencies for preceptorship in the basic health unit. Revista brasileira de enfermagem, 71, 1564-1571.

Finnegan, A., Finnegan, S., McKenna, H., McGhee, S., Ricketts, L., McCourt, K., & Thomas, M. (2016). Characteristics and values of a British military nurse. International implications of War Zone qualitative research. *Nurse education today*, *36*, 86-95.

Fleming, C. J. (2020). Prosocial rule breaking at the street level: The roles of leaders, peers, and bureaucracy. *Public Management Review*, *22*(8), 1191-1216.

Fowler, L. (2021). How to implement policy: Coping with ambiguity and uncertainty. Public Administration, 99(3), 581-597.

Friedman, M. I., Delaney, M. M., Schmidt, K., Quinn, C., & Macyk, I. (2013). Specialized new graduate RN pediatric orientation: A strategy for nursing retention and its financial impact. Nursing Economics, 31(4), 162-70.

Gale, N., Dowswell, G., Greenfield, S., & Marshall, T. (2017). Street-level diplomacy? Communicative and adaptive work at the front line of implementing public health policies in primary care. Social Science and Medicine, 177, 9–18

Geyer, L. T., Cunningham, T., Rastorguieva, K., & Ritenour, C. W. (2023). An Abundance Mindset Approach to Support Nurse Well-Being: The Feasibility of Peer Support. Nurse Leader.

Gobo, G. (2004). Sampling, representativeness and generalizability. *Qualitative research practice*, *405*, 426.

Godfrey, K. M., & Scott, S. D. (2021). At the Heart of the Pandemic:: Nursing Peer Support. Nurse Leader, 19(2), 188-193.

Goodsell, C. T. (2015). The new case for bureaucracy. Los Angeles, CA: SAGE

Grandey, A. A. (2000). Emotional regulation in the workplace: A new way to conceptualize emotional labor. *Journal of Occupational Health Psychology*, *5*(1), 95.

Greene, M. T., & Puetzer, M. (2002). The value of mentoring: A strategic approach to retention and recruitment. Journal of Nursing Care Quality, 17(1), 63-70.

Groeneveld, S., Tummers, L., Bronkhorst, B., Ashikali, T., & Van Thiel, S. (2015). Quantitative methods in public administration: Their use and development through time. *International Public Management Journal*, *18*(1), 61-86.

Guthrie, R., & Shayo, C. (2005). The Columbia disaster: Culture, communication & change. *Journal of Cases on Information Technology (JCIT)*, *7*(3), 57-76.

Guy, M.E., Newman, M.A., & Mastracci, S.H. (2008). *Emotional labor. Putting the service in public service*. Armonk, NY: M. E. Sharp, Inc.

Haigh, C., & Hardy, P. (2011). Tell me a story—a conceptual exploration of storytelling in healthcare education. Nurse education today, 31(4), 408-411.

Harris, M. (2007). The protégé and the sage: students' perceptions of work-based mentoring experiences. Health SA Gesondheid, 12(2).

Harnish, D., & Wild, L. A. (1994). Mentoring strategies for faculty development. Studies in Higher Education, 19(2), 191-201.

Hayhurst, A., Saylor, C., & Stuenkel, D. (2005). Work environmental factors and retention of nurses. *Journal of nursing care quality*, *20*(3), 283-288.

Helbing, E., Teems, M., & Moultrie, D. (2017). An investigation of job satisfaction among nurses in the emergency department. ABNF Journal, 28(4), 103– 108.

Hickey, G. M., Forest, P., Sandall, J. L., Lalor, B. M., & Keenan, R. J. (2013). Managing the environmental science–policy nexus in government: perspectives from public servants in Canada and Australia. Science and Public Policy, 40(4), 529-543.

Hofstede, G., Neuijen, B., Ohayv, D. and Sanders, G. (1990). Measuring organizational cultures: a qualitative and quantitative study across twenty cases. *Administrative Science Quarterly*, 35, 286-316.

Howlett, M. (2009). Policy analytical capacity and evidence-based policymaking: Lessons from Canada. Canadian public administration, 52(2), 153-175.

Hu, Y. Y., Fix, M. L., Hevelone, N. D., Lipsitz, S. R., Greenberg, C. C., Weissman, J. S., & Shapiro, J. (2012). Physicians' needs in coping with emotional stressors: the case for peer support. *Archives of Surgery*, *147*(3), 212-217.

Hupe, P., & Hill, M. (2007). Street-level bureaucracy and public accountability. Public administration, 85(2), 279-299.

Hurwitz, B., Greenhalgh, T., & Skultans, V. (Eds.). (2004). Narrative research in health and illness. BMJ books.

Institute for Heathlcare Improvement. (2008). Improvement Stories: No Nursing Shortage Here. Retrieved from http://www.ihi.org/resources/Pages/ImprovementStories/NoNursingShortageHere.aspx

Jacobs, A. M. and Weaver, R. K. (2015), Self-Undermining Feedback. *Governance*, 28: 441-457.

Jassim, T., Carlson, E., & Bengtsson, M. (2022). Preceptors' and nursing students' experiences of using peer learning in primary healthcare settings: a qualitative study. *BMC nursing*, *21*(1), 66.

Jha, S. K. (2018). Narrative texts in narrative inquiry: Interpretive voices to better understand experiences in given space and time. *Open Journal of Leadership*, 7, 237-249.

Johannessen, L. E. (2017). Beyond guidelines: discretionary practice in face-to-face triage nursing. *Sociology of health & illness*, *39*(7), 1180-1194.

Jones, M. D., & McBeth, M. K. (2010). A narrative policy framework: Clear enough to be wrong?. Policy studies journal, 38(2), 329-353.

Keulemans, S., & Van de Walle, S. (2020). Street-level bureaucrats' attitude toward clients: A study of work group influence in the Dutch and Belgian tax administration. Public Performance & Management Review, 43(2), 334-362.

Kim, K. H. (2007). Clinical competence among senior nursing students after their preceptorship. Journal of Professional Nursing, 23, 369–375.

Komaratat, S., & Oumtanee, A. (2009). Using a mentorship model to prepare newly graduated nurses for competency. *The Journal of Continuing Education in Nursing*, *40*(10), 475-480.

Kramer, N. (1993). Preceptorship policy is a tool for success. The Journal of Continuing Education in Nursing, 24(6), 274-276.

Lee, M., & Jang, K. S. (2019). Nurses' emotions, emotion regulation and emotional exhaustion. *International Journal of Organizational Analysis*, *27*(5), 1409-1421.

Lennox, S., Skinner, J., & Foureur, M. (2008). Mentorship, preceptorship and clinical supervision: three key processes for supporting midwives. New Zealand College of Midwives Journal.

Lessard, S., Caine, V., & Clandinin, D. J. (2019). Exploring neglected narratives: Understanding vulnerability in narrative inquiry. In *Journeys in Narrative Inquiry* (pp. 319-333). Routledge.

Linos, E., Ruffini, K., & Wilcoxen, S. (2022). Reducing burnout and resignations among frontline workers: A field experiment. *Journal of Public Administration Research and Theory*, *32*(3), 473-488.

Linton, M., & Koonmen, J. (2020). Self-care as an ethical obligation for nurses. Nursing ethics, 27(8), 1694-1702.

Lipsky, M. (2010). Street-level bureaucracy: Dilemmas of the individual in public service. Russell Sage Foundation.

Lipsky, M. (1980). Street Level Bureaucracy: Dilemmas of the Individual in Public Services. New York, NY: Russell Sage.

Lively, K. J. (2000). Reciprocal emotion management: Working together to maintain stratification in private law firms. Work and occupations, 27(1), 32-63.

Longo, J. (2011). Acts of caring: Nurses caring for nurses. Holistic Nursing Practice, 25(1), 8-16.

Lotta, G. S., & Marques, E. C. (2020). How social networks affect policy implementation: An analysis of street-level bureaucrats' performance regarding a health policy. Social Policy & Administration, 54(3), 345-360.

Loyens, K. (2019). Networks as unit of analysis in street-level bureaucracy research. In P. Hupe (Ed.), Research handbook on street-level bureaucracy. Cheltenham, UK: Edward Elgar

Lyman, B., Gunn, M. M., & Mendon, C. R. (2020). New graduate registered nurses' experiences with psychological safety. *Journal of nursing management*, *28*(4), 831-839.

MacDonald, C. (2002). Nurse autonomy as relational. *Nursing ethics*, 9(2), 194-201.

MacPhee, M., & Scott, J. (2002). The role of social support networks for rural hospital nurses: supporting and sustaining the rural nursing work force. *JONA: The Journal of Nursing Administration*, *32*(5), 264-272.

March, J. G., & and Olsen, J. P. (1995). Democratic Governance. New York: Free Press.

Maroulis, S. (2017). The role of social network structure in street-level innovation. *The American Review of Public Administration*, 47(4), 419-430.

Mastracci, S. H., Guy, M. E., & Newman, M. A. (2012). *Emotional labor and crisis response: Working on the Razor's edge*. Routledge.

Mastracci, S. H., Newman, M. A., & Guy, M. E. (2010). Emotional labor: Why and how to teach it. *Journal of Public Affairs Education*, *16*(2), 123-141.

May, P. J., & Winter, S. C. (2007). Collaborative service arrangements: Patterns, bases, and perceived consequences. *Public Management Review*, *9*(4), 479-502.

Maynard-Moody, S. W., & Musheno, M. C. (2022). *Cops, teachers, counselors: Stories from the front lines of public service*. Ann Arbor, Michigan: University of Michigan Press.

Maynard-Moody, S. W, & Musheno, M. C. (2012). Social equities and inequities in practice: Street-Level workers as agents and pragmatists. *Public Administration Review*, 72(s1), S16-S23.

Maynard-Moody, S., & Musheno, M. (2003). *Cops, Teachers, Counselors: Stories from the Front Lines of Public Service*. Ann Arbor, Michigan: University of Michigan Press.

Maynard-Moody, S., & Musheno, M. (2000). State Agent or Citizen Agent: Two Narratives of Discretion. *Journal of Public Administration Research and Theory*: J-PART,10(2), 329-358.

Mead, S., & MacNeil, C. (2006). Peer support: What makes it unique. *International Journal of Psychosocial Rehabilitation*, 10(2), 29-37.

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: a theoretical perspective. *Psychiatric rehabilitation journal*, 25(2), 134.

Melo, C. M. M. D., Florentino, T. C., Mascarenhas, N. B., Macedo, K. S., Silva, M. C. D., & Mascarenhas, S. N. (2016). Professional autonomy of the nurse: some reflections. *Escola Anna Nery, 20.*

Meyer, J. P., & Allen, N. J. (1997). *Commitment in the workplace: Theory, research, and application*. Sage publications.

Milliard, B. (2020). Utilization and impact of peer-support programs on police officers' mental health. *Frontiers in psychology*, 1686.

Mohamed, Z. N. J. M. M. L., Newton, J. M., & McKenna, L. (2014). Belongingness in the workplace: a study of Malaysian nurses' experiences. International Nursing Review, 61(1), 124-130.

Moore, M. H. (1995). *Creating public value: Strategic management in government*. Harvard university press.

Moore, P., & Cagle, C. S. (2012). The lived experience of new nurses: importance of the clinical preceptor. *Journal of continuing education in nursing*, 43(12), 555-565.

Morrison, E. W. (2006). Doing the job well: An investigation of pro-social rule breaking. *Journal of management*, *32*(1), 5-28.

Murphey, T., & Jacobs, G. M. (2000). Encouraging critical collaborative autonomy. *JALT Journal*, 22, 220-24

Nasurdin, A. M., Ling, T. C., & Khan, S. N. (2018). Linking social support, work engagement and job performance in nursing. *International Journal of Business & Society*, *19*(2).

Nisar, M. A., & Maroulis, S. (2017). Foundations of relating: Theory and evidence on the formation of street-level bureaucrats' workplace networks. *Public Administration Review*, *77*(6), 829-839.

Newstrom, J. W. (2007). *Organizational Behaviour-Human Behaviour at work* (12th ed). New York: McGraw Hill International Edition.

Norton, J. (2018). The science of motivation applied to clinician burnout: lessons for healthcare. Frontiers of health services management, 35(2), 3-13.

Oberfield, Z. W. (2014). *Becoming bureaucrats: Socialization at the front lines of government service*. University of Pennsylvania Press.

Ocasio, W. (1997). Towards an Attention-Based View of the Firm, Strategic Management Journal 18: 187–206.

O'donovan, R., & Mcauliffe, E. (2020). A systematic review of factors that enable psychological safety in healthcare teams. *International journal for quality in health care*, *32*(4), 240-250.

Omer, T. Y., & Moola, S. M. (2019). The Importance of the preceptor-preceptee relationship in creating well prepared professionals: A make or break experience.

Ospina, S., & Dodge. J. (2005a). It's about time: catching method up to meaning—The usefulness of narrative inquiry in public administration research. *Public Administration Review* 65:143–57.

———. (2005b.) Narrative inquiry and the search for connectedness: Practitioners and academics developing public administration scholarship. *Public Administration Review* 65:409–23

Otway, C. (2001). Informal peer support: a key to success for nurse prescribers. British Journal of Community Nursing, 6(11), 586-591.

Padgett, S. M. (2013). Professional collegiality and peer monitoring among nursing staff: An ethnographic study. *International journal of nursing studies*, 50(10), 1407-1415.

Panzavecchia, L., & Pearce, R. (2014). Are preceptors adequately prepared for their role in supporting newly qualified staff?. *Nurse education today*, 34(7), 1119-1124.

Parker, V., Giles, M., Lantry, G., & McMillan, M. (2014). New graduate nurses' experiences in their first year of practice. *Nurse Education Today*, 34(1), 150–156.

Penney, D. (2018). Defining "Peer Support": Implications for Policy, Practice, and Research. *Advocates for Human Potential, Inc*.

Pentland, B. T. (1999). Building process theory with narrative: From description to explanation. Academy of management Review, 24(4), 711-724.

Piemme, J. A., Tack, B. B., Kramer, W., & Evans, J. (1986). Developing the nurse preceptor. *The Journal of Continuing Education in Nursing*, *17*(6), 186-189.

Pleiss, M. K., & Feldhusen, J. F. (1995). Mentors, role models, and heroes in the lives of gifted children. *Educational psychologist*, *30*(3), 159-169.

Pursio, K., Kankkunen, P., Sanner-Stiehr, E., & Kvist, T. (2021). Professional autonomy in nursing: An integrative review. *Journal of Nursing Management*, *29*(6), 1565-1577.

Race, T. K., & Skees, J. (2010). Changing tides: Improving outcomes through mentorship on all levels of nursing. *Critical Care Nursing Quarterly*, *33*(2), 163-174.

Rafaeli, A., & Sutton, R. I. (1987). Expression of emotion as part of the work role. *Academy of management review*, 12(1), 23-37.

Randolph, S. A. (1988). Occupational health nursing: a commitment to excellence. *AAOHN journal*, *36*(4), 166-169.

Rantung, G., Griffiths, D., Plummer, V., & Moss, C. (2022). How emergency nurses cope and motivate themselves to sustain their caring work: An integrative literature review. *Journal of Clinical Nursing*, *31*(7-8), 843-859.

Rauhaus, B. M. (2022). Public Service Motivation of Street-Level Bureaucrats Amidst the COVID-19 Pandemic: An Analysis of Experiences in Implementation of an at-Home Vaccination Program. *State and Local Government Review*, *54*(1), 82-91.

Rebeiro, G., Edward, K.-l., Chapman, R., & Evans, A. (2015). Interpersonal relationships between registered nurses and student nurses in the clinical setting—A systematic integrative review. Nurse Education Today.

Reed, G. E. (2004). Toxic leadership. *Military review*, *84*(4), 67-71.

Riessman, C.K. (2008) Narrative Methods for the Human Sciences. Thousand Oaks, CA: Sage

Rhodes, R. A. (2007). Understanding governance: Ten years on. Organization studies, 28.8, 1243–1264.

Roe, E. (1994). Narrative policy analysis: theory and practice. Durham, NC: Duke Univ. Press.

Roe, E. (1989). Narrative analysis for the policy analyst: A case study of the 1980–1982 medfly controversy in California. Journal of Policy analysis and management, 8(2), 251-273.

Rousseau, V., Salek, S., Aubé, C., & Morin, E. M. (2009). Distributive justice, procedural justice, and psychological distress: The moderating effect of coworker support and work autonomy. Journal of Occupational Health Psychology, 14(3), 305-317.

Rudel, R. J. (2006). Nontraditional nursing students: The social influences on retention. Teaching and Learning in Nursing, 1(2), 47-54.

Rutz, S., Mathew, D., Robben, P., & de Bont, A. (2017). Enhancing responsiveness and consistency: Comparing the collective use of discretion and discretionary room at inspectorates in E ngland and the N etherlands. *Regulation & Governance*, *11*(1), 81-94.

Sahay, S., & Wei, W. (2022). “Everything Is Changing, but I Am Not Alone”: nurses’ perceptions of social support during COVID-19. *Sustainability*, *14*(6), 3262.

Scandura, T. A., & Hamilton, B. A. (2002). Enhancing performance through mentoring. Psychological management of individual performance, 293-308.

Shapiro, J., & Galowitz, P. (2016). Peer support for clinicians: a programmatic approach. *Academic Medicine*, *91*(9), 1200-1204.

Schein, E. H., & Schein, P. (2016). Organizational culture and leadership (5th ed.). New York: John Wiley & Sons, Incorporated.

Schellenberg, M., Docherty, S., Owattanapanich, N., Emigh, B., Lutterman, P., Karavites, L., ... & Inaba, K. (2023). Emergency physician and nurse discretion accurately triage high-risk trauma patients. *European Journal of Trauma and Emergency Surgery*, *49*(1), 273-279.

Schmidt, K. L. (2015). Transforming Practice—Learning from Our Peers. *Journal for Nurses in Professional Development*, *31*(3), 127.

Schön, D. A. (1987). Educating the reflective practitioner: Toward a new design for teaching and learning in the professions. Jossey-Bass.

Schroyer, C. C., Zellers, R., & Abraham, S. (2016). Increasing registered nurse retention using mentors in critical care services. The health care manager, 35(3), 251-265.

Sedgwick, M., & Harris, S. (2012). A critique of the undergraduate nursing preceptorship model. Nursing research and practice.

Selznick, P. (1957). Leadership in administration. Berkeley.

Shim, D. C., Park, H. H., Keum, J., & Kim, S. (2021). Street-level bureaucrats’ work engagement: Can public managers’ servant-leader orientation make a difference?. *Public Personnel Management*, *50*(3), 307-326.

Siciliano, M. D. (2017). Professional networks and street-level performance: How public school teachers’ advice networks influence student performance. *The American Review of Public Administration*, *47*(1), 79-101.

Siciliano, M. D. (2015). Advice networks in public organizations: The role of structure, internal competition, and individual attributes. Public Administration Review, 75(4), 548-559.

Shamian, J., & El-Jardali, F. (2007). Healthy workplaces for health workers in Canada: knowledge transfer and uptake in policy and practice. *Healthcare Papers*, *7*(I), 6.

Skår, R. (2010). The meaning of autonomy in nursing practice. *Journal of clinical nursing*, *19*(15-16), 2226-2234.

Smith, B., Collinson, J. A., Phoenix, C., Brown, D., & Sparkes, A. (2009). Dialogue, monologue, and boundary crossing within research encounters: A performative narrative analysis. International journal of sport and exercise psychology, 7(3), 342-358.

Smith, L. S., McAllister, L. E., & Crawford, C. S. (2001). Mentoring benefits and issues for public health nurses. Public health nursing, 18(2), 101-107.

Snowdon, A. W., & Rajacich, D. (1993, March). The challenge of accountability in nursing. In Nursing Forum (Vol. 28, No. 1, pp. 5-11). Oxford, UK: Blackwell Publishing Ltd.

Soss, J. & Donald P. M. (2014). "Policy Feedback and the Politics of Administration." Public Administration Review 74 (3): 320–32. doi:10.1111/puar.12200.

Stinglhamber, F. and Vandenberghe, C. (2003). Organizations and supervisors as sources of support and targets of commitment: A longitudinal study. Journal of Organizational Behavior, 24, 251–270.

Tamer, İ., & Dereli, B. (2014). The relationship between interpersonal trust, peer support and organizational commitment. Öneri Dergisi, 11(42), 175-196.

Tanaka, M., Taketomi, K., Yonemitsu, Y., & Kawamoto, R. (2016). Professional behaviours and factors contributing to nursing professionalism among nurse managers. Journal of Nursing Management, 24(1), 12–20.

Taylor, J. (2008). Organizational influences, public service motivation and work outcomes: An Australian study. *International Public Management Journal*, *11*(1), 67-88.

Taylor, J. (2013). Public service motivation, relational job design, and job satisfaction in local government. *Public Administration*, *92*(4), 902-918.

Teodoro, M. P. (2009). Bureaucratic job mobility and the diffusion of innovations. *American Journal of Political Science*, *53*(1), 175-189.

Thorne, S. (2008). Interpretive Description. Left Coast Press, Walnut Creek: CA.

Tourigny, L., & Pulich, M. (2005). A critical examination of formal and informal mentoring among nurses. The health care manager, 24(1), 68-76.

Tuckett, A., Winters-Chang, P., Bogossian, F., & Wood, M. (2015). 'Why nurses are leaving the profession… lack of support from managers': What nurses from an e-cohort study said. International journal of nursing practice, 21(4), 359-366.

Tummers, L. (2011). Explaining the willingness of public professionals to implement new policies: A policy alienation framework. International Review of Administrative Sciences,77, 555–581.

Tummers, L., Steijn, B., & Bekkers, V. (2012). Explaining the willingness of public professionals to implement public policies: Content, context, and personality characteristics. Public Administration, 90(3), 716-736.

Vahey, D.C., Aiken, L.H., Sloane, D.M., Clarke, S. P., & Vargas, D. (2004). Nurse burnout and patient satisfaction. *Medical Care*, 42 (2suppl), II-57 – 66.

Van den Broek, J., Boselie, P., & Paauwe, J. (2017). Multiple institutional logics in health care:'productive ward: releasing time to care'. In *Innovation in Public Services* (pp. 70-89). Routledge.

Van Emmerik, I. H., Euwema, M. C., & Bakker, A. B. (2007). Threats of workplace violence and the buffering effect of social support. Group & Organization Management, 32(2), 152-175.

Van Engen, N., Tummers, L., Bekkers, V., & Steijn, B. (2016). Bringing history in: Policy accumulation and general policy alienation. *Public Management Review*, *18*(7), 1085-1106.

Van Maanen, J. E., & Schein, E. H. (1977). Toward a theory of organizational socialization. Cambridge, MA: Massachusetts Institute of Technology.

Van Patten, R. R., & Bartone, A. S. (2019). The impact of mentorship, preceptors, and debriefing on the quality of program experiences. Nurse education in practice, 35, 63-68.

Van Pelt, F. (2008). Peer support: healthcare professionals supporting each other after adverse medical events. *Quality & safety in health care*, *17*(4), 249.

Vashdi, D. R. (2013). Teams in public administration: A field study of team feedback and effectiveness in the Israeli public healthcare system. *International Public Management Journal*, *16*(2), 275-306.

Vedung, E. (2015). Autonomy and street-level bureaucrats' coping strategies. *Nordic Journal of Studies in Educational Policy*, *2015*(2), 28643.

Vidal, J. A. M., & Olley, R. (2021). Systematic literature review of the effects of clinical mentoring on new graduate registered nurses' clinical performance, job satisfaction and job retention. *Asia Pacific Journal of Health Management*, 16(4), 70-82.

Vigoda, E. (2002). From responsiveness to collaboration: Governance, citizens, and the next generation of public administration. *Public administration review*, *62*(5), 527-540.

Walker, L., & Gilson, L. (2004). 'We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa. *Social science & medicine*, 59(6), 1251-1261.

Warelow, P., & Edward, K. L. (2007). Caring as a resilient practice in mental health nursing. *International journal of mental health nursing*, *16*(2), 132-135.

Watson, C. (2006). Narratives of practice and the construction of identity in teaching. Teachers and Teaching: theory and practice, 12(5), 509-526.

Weber, M. (1978). Economy and Society. Ed. G. Roth, C. Wittich. Berkeley: University of California Press.

Weng, R. H., Huang, C. Y., Tsai, W. C., Chang, L. Y., Lin, S. E., & Lee, M. Y. (2010). Exploring the impact of mentoring functions on job satisfaction and organizational commitment of new staff nurses. *BMC Health Services Research*, 10(1), 1-9.

Wilson, J. Q. (1989). *Bureaucracy: what government agencies do and why they do it*. Basic Books

Wilson, J. Q. (2009). *Varieties of police behavior: The management of law and order in eight communities*. Harvard University Press.

Wong, A., & Trollope-Kumar, K. (2014). Reflections: an inquiry into medical students' professional identity formation. *Medical education*, *48*(5), 489-501.

World Health Organization. (1998). Ottawa Charter for Health Promotion (Revised): International Conference on Health Promotion. Geneva, Switzerland.

Yang, Z., & Nowell, B. (2021). Network isomorphism?: A network perspective on the symbolic performance of purpose-oriented networks. *International Public Management Journal*, *24*(3), 350-377.

Younger, J. B. (1991). A theory of mastery. Advances in Nursing Science, 14(1), 76-89.

Zacka, B. (2017). When the state meets the street. Harvard University Press.

Zarshenas, L., Sharif, F., Molazem, Z., Khayyer, M., Zare, N., & Ebadi, A. (2014). Professional socialization in nursing: A qualitative content analysis. Iranian journal of nursing and midwifery research, 19(4), 432–438.

Zhang, H., Yang, L., Walker, R., & Wang, Y. (2022). How to influence the professional discretion of street-level bureaucrats: transformational leadership, organizational learning, and professionalization strategies in the delivery of social assistance. *Public Management Review*, *24*(2), 208-232.

Appendices

Appendix A: Research Framework

This dissertation builds on and extends the supporting materials and narrative analysis framework developed in Bredenkamp (2022) such as the information sheet, and analysis and interpretation protocol.

Appendix B: Google Form Survey

Cultivating Professional Meaning and Organizational Commitment: Frontline Nurses Stories about Peer Support Survey

Please fill out this form with information about yourself and your level of experience if you are a public hospital emergency nurse, mental health nurse, or military nurse who wants to participate in this study.
Thank you!

Amady Sogodogo (amadys@vt.edu) **and Matt Dull** (mdull@vt.edu)
Center for Public Administration & Policy, School of Public & International Affairs
Virginia Tech Research Center, 900 North Glebe Road, Arlington, VA 22203

* Required

1. What is your name? *

_____

2. Which of the following genders best describes you? *

Mark only one oval.

- ◯ Female
- ◯ Male
- ◯ Prefer not to say
- ◯ Other: _____

3. What is your email? *

_____

4. **Nurse Specialty. Please select one:** *

Mark only one oval.

- ◯ Emergency nurse
- ◯ Mental health nurse
- ◯ Military nurse

5. Do you work at a public hospital? *

Mark only one oval.

- ◯ Yes
- ◯ No

6. Do you have at least 1 to 2 years of public-sector nursing experience? *

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Maybe
- ◯ Other: _____

7. Do you have at least 5 to 10 years of public-sector nursing experience? *

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Maybe
- ◯ Other: _____

8. Do you have at least 1 to 2 years of experience in the same hospital you are currently working at? *

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Maybe
- ◯ Other: _____

9. Have you ever had a preceptorship or mentorship or something in between these at work? If so, can you describe it? *

_____

_____

_____

_____

_____

10. Thank you for your interest. We will be in touch soon as we are quickly selecting study participants.

    Please use the space below for any additional questions or comments, or you can also email Amady Sogodogo at amadys@vt.edu.

Appendix C: Recruiting Email

Hello frontline nurses,

Are you an emergency nurse, a mental health nurse or a military nurse? If so, researchers at Virginia Tech School of Public and International Affair are interested in your experiences and the nuances that go into caring for vulnerable Americans.

My name is Amady Sogodogo, and this public research study is the focus of my dissertation. I am currently a PhD student at Virginia Tech. Specifically, we are conducting in depth interviews to better understand the importance of frontline nurses' perceptions of peer support in improving their working conditions. If you choose to participate and interview with us, you will be introduced to Dr. Matthew Dull, my dissertation chair, who will act as an observer, as I serve as the interview facilitator.

We are contacting you because your work is important to us, and we would like to learn more about why you value peer support. As we compare the impact of peer support on nurses' care delivery, we want to better understand your perception of how peer support affects nurses' motivation and professional/organizational commitments. We are interviewing nurses like you about how they perceive peer support in improving their working conditions. Your perspectives as a frontline supporter of the American healthcare system are critical in developing a more holistic and comprehensive view of peer support in the clinical setting.

As part of the study, we would also ask you about a work experience or story that helps us understand the role of peer support in healthcare service delivery. We are collecting stories from public hospital emergency nurses, mental health nurses, and military nurses. Participants in this study will be interviewed on Zoom for a 45–60-minute interview. For accuracy, interviews will be recorded and transcribed. The Information Sheet contains additional information about the study.

We will send you another email to schedule an interview once you have agreed to participate in this study. If you need more information or have any questions, please email amadys@vt.edu or call (443) 422-7928 during business hours (8:00 AM-5:00 PM).

Thank you for your consideration,
Amady T. Sogodogo and Matthew Dull, PhD

Appendix D: Verbal Introduction

Welcome and thank you in advance for your contributions to this research study. I am conducting this study to better understand the important work nurses like you perform. First, in this recorded interview, I will ask you to tell me a bit about what type of nurse you are and your career.

I will then ask you to tell me a story about an experience at work that helps me understand how preceptorship or mentorship influence your job.

The whole interview should last between 30- and 45-minutes total.

Your participation in this study is entirely voluntary and strictly confidential. This interview will be recorded, and you will be given an anonymous identifying number. The audio sections will be kept for accuracy. To safeguard your identity, any names or other personally identifying information about yourself, coworkers, your workplace, or patients will be removed from the transcript.

Do you have any questions before we begin?

Appendix E: Interview Questions

Q1: Please take 5 minutes to tell me how many years you have been the type of nurse you are and why do you think being that type of nurse is different from other nurses?

Q2: Please tell me a story about one or more workplace experiences that help me understand the impact of preceptorship or mentorship, or peer support on your job.

Follow ups:

Can you please describe if it was a formal or informal training that you received?

What happened?

Where and when?

How did you respond?

How and why does this story reflect the impact of colleague support on your job?

Q3: How does this story tell me why this formal or informal training made you feel about your job?

Follow ups:

Did you feel like you had autonomy- the ability to act freely on one's own judgment?

Did you feel like you had mastery- confidence about your skills?

Did you feel like you had a professional purpose?

Q4: What can we learn from this story about your formal interactions or connections with peers?

Follow ups:

What can I learn from this story about your informal interactions or connections with peers?

Q5: What does this story tell me about your workplace climate or peer support and its impact on your motivation to care for patients? care about quality care delivery?

Q6: What does this story tell me about the impact of your peer support on your role as a nurse?

Follow ups:

Why do you do what you do?

Q7: How does this story tell me about your level of commitment to your colleagues and organization? I feel like I own to them Do you want to give back to her peers and organization.

Follow ups:

Why?

Is it because you want to give back to your peers?

Q8: Did COVID19 make you closer to your peers?

Follow ups:

Do you think the social interaction increased during COVID19 and helped you do your job well?

Q9: Do you think an organization should create a peer support program to help nurses be productive?

Appendix F: Information Sheet

Information Sheet for Participation in a Research Study

Principal Investigator: Amady T. Sogodogo
IRB#:
Title of Study: Cultivating Professional Meaning and Organizational Commitment: Frontline Nurses Stories about Peer Support

You are invited to take part in a research study that will explore the experiences or stories of frontline nurses regarding the impact of peer support on their care delivery process. This form contains information about the study as well as contact information in case you have any questions. We are looking for stories about your peer support and how you perceive peer support in a clinical setting. We intend to collect and analyze stories told by military nurses, mental health nurses, and emergency room nurses working in public hospitals. You are identified as a potential study participant because you work as one of these nurses. If you want to participate, please read this Information Sheet and send any questions to amadys@vt.edu or (443) 422-7928 during regular business hours (8:00AM-5:00PM).

WHAT SHOULD I KNOW?

STUDY PURPOSE

The goal of this research is to gain a more comprehensive understanding of the relational and social dimensions of professional and organizational commitments for nurses. Do formal (preceptorship) or informal (mentoring) peer support experiences influence how you associate meaning to your profession, how you do your work, and how you commit to your organization? By focusing on personal narratives, we hope to put lived experiences (like yours) at the center of the research.

NUMBER OF PEOPLE TAKING PART IN THE STUDY:

We plan to collect stories from between 30 and 36 (ideally 10 or 12 from each group) from public hospital military nurses, mental health nurses, and emergency room nurses.

PROCEDURES FOR THE STUDY:

If you agree to participate in the study, you will take part in a single interview that will last 35-60 minutes and will focus on a single foundational question:

> *Please tell us a story about one or more workplace experiences that have helped you understand the impact of preceptorship, mentorship, or peer support on your job and commitment to your profession and workplace.*

Two members of the research team will conduct interviews via Zoom video. The team will keep audio recordings to accurately convey your thoughts.

RISKS OF TAKING PART IN THE STUDY:

We believe the risks of participating in the interview are minimal. Because you are in an environment where you feel comfortable using Zoom, you are in charge of telling your own story and voluntarily answering a question. The interview questions should not be sensitive or controversial. If you are uncomfortable answering a question at any point during the process, you may decline to respond or even end the interview and have all records of your interview destroyed. You may do so without putting yourself or your organization at risk.

BENEFITS OF TAKING PART IN THE STUDY:

While no monetary incentive will be given, many people find the opportunity to reflect on their public service experiences and commitment to serving vulnerable Americans enjoyable and rewarding. Moreover, you will be helping further our understanding of how peer support experiences impact positive outcomes for nurses working with vulnerable populations.

CONFIDENTIALITY

The confidentiality of your personal information is a team priority. Your identity will be kept private in any publications related to this study. Only a code number will be used to identify the recording of your interview. The file linking the code number to your name, as well as the audio file of your interview, will be deleted at the end of the study. Groups such as the study investigator and dissertation committee, the Virginia Tech Institutional Review Board, or its designees, and (as permitted by law) state or federal agencies, specifically the Office for Human Research Protections, may inspect and/or copy the research records for quality assurance and data analysis (OHRP).

COSTS & PAYMENTS

There are no costs or financial incentives for taking part in this study.

VOLUNTARY NATURE OF STUDY

Participation in this study is entirely voluntary. You may choose not to participate or withdraw from the study at any time with no consequences to you or your organization. Your decision to participate or not participate in this study will have no bearing on your current or future relationships with Virginia Tech or any of its academic or administrative units.

WHO CAN I TALK TO?

During regular business hours, call Amady T. Sogodogo at (443) 422-7928 with any questions about the study (8:00AM-5:00PM). Because of your participation in this research study, you are not waiving any legal claims, rights, or remedies. If you have any questions about your rights as a research participant, please contact the HRPP Office at Virginia Tech at 540-231-3732 (irb@vt.edu).

Please print out a copy of this information sheet for your records.

If you would like to participate in this study, please contact amadys@vt.edu to express interest.

RESEARCH TEAM

We look forward to talking with you, and we thank you for your participation.

Sincerely,

Amady T. Sogodogo and Matthew Dull.

Appendix G: Data Collection Steps and Data Analysis and Interpretation Protocol

Data Collection Steps

Stage 1 - **Response, Information Sheet**	Stage 2**- Interviews**
▪ Post Google survey form online. ▪ Select eligible participants. ▪ Send Recruitment email. ▪ Distribute Information sheet. ▪ Follow up email to schedule Interviews	▪ Conduct 45 to 60 minutes semi-structured interviews via Zoom

Data Analysis and Interpretation Protocol

Stage 1**- After Each Interview**	Stage 2 **- Reading and Reflections**	Stage 3 **- Coding Process Using Delve**
▪ Verbatim automated Zoom transcription of in-depth interviews ▪ Place Zoom audio transcripts in a password-protected Google Drive folder. ▪ Remove personal Information. ▪ Read and clean transcripts for accuracy ▪ Conduct a post-interview (if necessary).	▪ Re-read transcripts. ▪ Write reflections about major takeaways and themes: peer support, professional meaning, organizational commitment, supportive work environment.	▪ Code inductively when analyzing data. ▪ Implement an open, thematic, and axial coding process. ▪ Divide codes into main themes and subthemes. ▪ Cluster essential texts or quotations.