

The Experience of Students and Newly-Licensed Nurses with Learning Disabilities in
Transition to Clinical Nursing Practice

By

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Abstract

Nursing students and new nurses with learning disabilities (LDs) are at risk for school and work-related transition failures, yet little is known about how best to support this group in pre- and post-licensure transitions to clinical practice (TTP). Through this critical interpretive study I explored what pre- and post-licensure TTP was like for persons with LD from the perspectives of those living the experience. I conducted 23 total interviews involving eight participants. I used a narrative life history method with the disability studies model as a critical lens in collecting, analyzing, and interpreting the data. Data collection and analyses occurred simultaneously. Analysis resulted in the core narrative of *The Battle of Becoming*. I re-presented participants' experiences of the battle via ten data based short stories, composite in form. The stories offer a window into the complex lives and experiences of individuals with LD as well as broader societal conditions and ideologies that exist within and outside of the nursing profession. Participants acted courageously to surmount ideologies of ability that presented in their career paths. In the face of adversity, participants' acts were demonstrative of personal resilience and professional integrity in achieving their non-negotiable objective of becoming safe, competent, and effective nurses. The application of a critical lens fostered a re-theorization of ability-disability as contextual, not simply stagnant and dichotomous in form. The results of this work point to the need for cultural competence specific to disability in nursing education and practice, the revision of policies at multiple levels, and a cultural shift toward inclusivity and civility within the profession. Further studies are needed to investigate root causes of TTP success in NL RNs with/without disabilities.

Keywords: Disability, nurses, nursing students, transitions

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1. Overview of the Short Stories

Figure.

1. TTP Experiences of Interest

Chapter 1: Introduction

Study Overview

This study is the first to explore and describe what pre- and post-licensure transition to practice (TTP) is like for persons with learning disabilities (LDs) from the perspectives of those living the experience. Minimal research exists on persons with LD attending nursing schools, and no research exists on their transition-to-practice (TTP) experiences prior to and/or post-licensure. Furthermore, vocational outcomes in relation to TTP have not been examined with this nursing workforce in mind.

To date, theoretical knowledge related to students with LDs includes aspects of students' academic and clinical challenges (Eliason, 1992; Ijiri & Kudzma, 2000; Letizia, 1995; Sanderson-Mann & McCandless, 2006; White, 2007), classroom and clinical teaching strategies (Colon, 1997; McCleary-Jones, 2008; Tumminia & Weinfield, 1983), commonly requested student accommodations (Colon, 1997; Eliason, 1992; Meloy & Gambescia, 2014; Selekman, 2002; Shellenbarger, 1993), faculty knowledge and their attitudes toward students with LDs (Magilvy & Mitchell, 1995; Sowers & Smith, 2004), and disability law relevant to nursing education (Dupler, Allen, Maheady, Fleming, & Allen, 2012; Helms, Jorgensen, & Anderson, 2006; Sanderson-Mann & McCandless, 2006). Despite what is known from this theoretical base, few nursing research studies exist on students or newly licensed (NL) RNs with LDs, and studies have yet to address pre- and/or post-licensure TTP. Therefore, the primary goal of this study is to understand what pre- and post-licensure TTP is like for persons with LDs.

Background

Learning disability.

LD is an umbrella term for a wide variety of specific problems that can directly impact learning. The term LD is often used generically within the nursing literature and frequently conceptualized and defined via a medical lens. From this perspective, LD is described as a heterogeneous group of disorders that interferes with the development, integration, and/or demonstration of verbal and nonverbal abilities (Rosebraugh, 2000; Ijiri & Kudzma, 2000; Selekman, 2002), as well as higher order skills including organization, time management, and abstract reasoning (Learning Disabilities Association [LDA] of America, 2004). LDs are reported to manifest as anomalies in listening, thinking, speaking, reading, writing, spelling, or doing mathematical calculations (U.S Department of Education, 2006). Not associated with deficiencies in intelligence or motivation, rather LDs are presumed neurological in nature, chronic, and intrinsic to the individual (Accardo, Haake, Whitman, 1989; Eliason, 1992; Ijiri & Kudzma, 2000; Rosebraugh, 2000; Selekman, 2002; Tummina & Weinfield, 1983). Of note, approximately 32 percent of persons with LD also have a co-existing diagnosis of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) (Kolanko, 2003).

More than 10% of undergraduate students identify as having a disability and almost half of this group reports that learning is their primary disability (Helms et al., 2006). These figures are likely underestimates of the prevalence of LD in higher education, since 50% of undergraduate college students with LDs are undiagnosed before entering their academic programs (Rosebraugh, 2000; McCleary-Jones, 2008).

There are no national figures on the numbers of students in nursing with LDs, though rough data collected from one local-area university suggested nursing student disclosures of disability have tripled from 2008 to 2011 (S. Orchard, OHSU Student Access Services, personal communication, 2011). Also consistent with national data, half of this group indicated learning was their primary difficulty (S. Orchard, OHSU Student Access Services, personal communication, 2011).

Impact of disability on education.

It is important to note that high school dropout rates are two to three times higher for those with LD than students without disability (Gregg, 2007). Furthermore, persons with LD attend college at a rate of one-tenth that of the general public (Gregg, 2007). Although federal law mandates most academic institutions to provide access and supportive services to persons with LD to improve post-secondary educational outcomes, the educational attainment of this group remains substantially below that of their non-disabled counterparts (Gregg, 2007). Educational outcomes for persons with LD may be further diminished when other factors like socio-economic status, race, gender, ethnicity, and sexual orientation intersect the experience (Gregg, 2007).

Although there is an abundance of theoretical discourse on how best to support students with LD and facilitate their transition to post-secondary institutions (Bates, 1997; Dowrick, Anderson, Heyer, & Acosta, 2005; Madaus, 2005; Madaus & Shaw, 2006; Mellard, 2005; Milsom & Hartley, 2005; National Joint Committee on Learning Disabilities [NJCLD], 2007; Siperstein, 1988; Sitlington, 2003; Skinner & Lindstrom, 2003), little is known about the transition of students to professional

practice-based programs like those of nursing, medical, dental, and law schools. Moreover, TTP experiences specific to clinical learning and their impact on nursing students have yet to be explored.

Although there is no TTP research related to pre-licensure experiences in nursing school, there is one U.S. nursing study that described the experience of students with LD in the clinical setting. Here, students reported having performance anxiety, difficulty comprehending oral directions, and low self-confidence in learning situations (Kolanko, 2003). The participants in Kolanko's study said that being a nursing student with LD means to struggle to stay in program, manage anxiety, and accept and maintain autonomy. The experience of these students is important to consider given that many persons with LD have difficulty remaining in and graduating their post-secondary programs (Janiga & Costenbader, 2002).

Classroom and clinical accommodations may reduce students' stress and anxieties and help them meet their educational goals. And, all academic institutions that receive state and/or federal funding are obligated by law to provide students with LD reasonable accommodations upon disclosure and documentation of their disability. However, the minimal research that exists within nursing suggests that students with LD do not readily disclose their learning difficulties because they fear stigma associated with the label of disability and subsequent discrimination by faculty (Kolanko, 2003; Sanderson-Mann & McCandless, 2006).

Impact of disability on employment.

Even if students with LD successfully graduate their post-secondary programs, their employment outlook and prospects remain bleak. It is well

documented that persons with LDs are often unemployed, underemployed, and at significant risk for job failure upon completion of their academic programs (Gerber, Price, Mulligan, & Shessel, 2004; Gregg, 2007; Koller, 1994; Madaus, Gerber, & Price, 2008a). Risk for job failure increases when individuals with LDs lack career maturity and are not involved soon enough in transition planning processes (Koller, 1994). The absence of career coaching, identification of inappropriate career goals (Koller, 1994); poor understanding and use of the Americans with Disabilities Act (ADA) protections (Madaus et al., 2008; Price, Gerber, & Mulligan, 2007; Sowers & Smith, 2004); and stigma, fear, and misunderstandings related to disclosure of LD in the workplace (Gerber, 2009) also contribute to poor employment outcomes for persons with LD. Like those in the post-secondary setting, persons with LD have a choice in disclosing their disability in the workplace. For a host of reasons including stigma and fear of discrimination by their supervisors and peers, most persons with LD do not disclose their learning difficulties to their employers (Gerber, 2009; Madaus, Zhao, Ruban, 2008b; Price et al., 2007). Unfortunately, without disclosure in the workplace they are ineligible for ADA protections or reasonable accommodations that may in fact promote their transition to work and vocational success (Madaus et al., 2008a).

Given the impact of LD on employment, it is posited that early transition planning must be implemented in order to potentiate individuals' habits of self-advocacy and knowledge essential for successful employment (Madaus et al., 2008a). For persons with LDs, it is recommended that pre-transition activities include education on ADA and related rights and responsibilities, methods and timing of

disclosure, role transition theory, and self-advocacy (Gerber, 2009). Although there is scant evidence indicating some U.S. nursing students with LDs enter and graduate their programs (Colon, 1997) and work in clinical practice settings post-licensure (Copeland, Chan, Bezyak, & Fraser, 2010), no studies to date have considered their TTP-related experiences or challenges (like disclosure, access, discrimination, or stigma) and/or relevant success factors (e.g., pre-transition planning, ADA-related education, or self-advocacy training) specific to those with LD.

Transition to practice (TTP).

No matter the context - education or work, transition is a psychological process involving three phases including an ending, a neutral zone, and a new beginning (Bridges, 2009). Conversely, change is an external experience that does not always prompt the internal process of transitioning (Bridges, 2009). Transition theory suggests transitions are triggered by critical events or changes in individuals and/or their environments (Meleis, 2010). In this study, TTP is broadly equated with situational, developmental, and/or organizational transition experiences that occur as one attempts and is expected to learn within the authentic practice environments (APEs) of practicing nurses. Thus, TTP is typically experienced by students while in their nursing programs and by new graduates as they enter the workforce as NL RNs.

In general, TTP involves changes in identities, roles, relationships, abilities, and patterns of behavior, and is reflective of varying stages, significant accomplishments, and critical turning points (Meleis, 2010). Students and new nurses subjectively experience endings and new beginnings (Bridges, 2009) relevant to each of these various changes. In TTP, students and new RNs attempt to locate stability in

their lives and congruence in shifting personal and professional expectations and ideals. As such, they often describe being in a state of “in-betweeness” (Blair, 2000; Boychuk Duchscher, 2009; Gerber, 2009; Meleis, 2010). Though there is much opportunity for positive developments in this neutral zone, it can also be a dangerous time (Bridges, 2009). It prompts anxiety in many individuals, as well as feelings of resentment, self-doubt, confusion, and vulnerability (Meleis, 2010). As a result, some may exit the transition process here (potentially ending their academic pursuits or leaving the nursing profession altogether), in order to return to a prior more comfortable and recognizable reality (Bridges, 2009).

Pre-licensure TTP.

There are common pre-licensure transitions embedded within nursing curricula to ease students’ TTP post-licensure and retain them in the profession thereafter. For example, most students are exposed to multiple clinical practice settings during their nursing programs, sometimes upwards of 10 different types of nursing work environments. These pre-licensure transitions may include, but are not limited to, hospitals, community agencies, home healthcare, hospice care, rehabilitation centers, and primary care offices. In general, students learn and practice in these settings for time periods of approximately four to 10 weeks. This pedagogical practice gives students a basic feel for different kinds of nursing work and offers them the opportunity to see first-hand what it might be like to work in one of these settings in their future as RNs.

In addition, students typically participate in a preceptorship (also known as a clinical capstone or integrative practicum) during the final year of their program. This

is an intensive, reality-based pre-graduation clinical experience intended to facilitate the post-graduation transition of students into the real world of nursing practice (Laschinger & MacMaster, 1992; Udalis, 2008; Wieland, Altmiller, Dorr, & Wolf, 2007). Rather than clinical faculty, preceptors (who are nurses employed within the practice setting) provide primary clinical oversight and facilitation of student learning during this course. Preceptorships have been researched to some extent both by quantitative and qualitative means, and findings regarding their effects on student learning and professional role development are mixed. This is likely because the preceptorship experience is inclusive of variable features (e.g., people, history, political forces, culture, hierarchies, and power-differentials) that either promote and/or impede students' transition to the setting, the uptake of their role, and ultimately their learning during the course.

Though there is a breadth of information regarding conditions that facilitate students' learning in the clinical setting, including the preceptorship (Kim, 2003; Watt, Murphy, Pascoe, Scanlon, & Gan, 2011; Wieland et al., 2007), what remains missing from the literature is the preparatory activity or pre-transition planning intended to support students' continued learning and development through the TTP experience itself (DeWolf, Perkin, Harrison, Laschinger, Oakley, Peterson, & Seaton, 2010). No research to date has examined preparatory strategies specifically related to pre-licensure TTP for nursing students in general or those with LD, yet the LD literature strongly urges pre-transition planning to promote student success (Madaus et al., 2008a).

Specifically for nursing students with LD, theoretical and experiential works recommend students and faculty meet before students transition to new clinical placements to discuss the setting, expectations, and their learning support needs (Dupler et al., 2012). In addition, faculty ought to allow students' time to consider accommodations as new situations present in the clinical setting (Dupler et al., 2012); review clinical procedures and evaluation processes before TTP and regularly thereafter; praise students' efforts and reinforce their strengths (Shellenbarger, 1993); and incorporate principles of universal design in all teaching-learning practices (Lombardi & Murray, 2011).

Post-licensure TTP.

Though the clinical practice setting remains the scene for continuous learning for NL RNs in the post-licensure period, the mandate represented by licensure to uphold one's individual RN role obligation (to protect the public from harm) is an additional feature of this TTP experience. Thus, NL RNs experience, perhaps to a more significant degree than student nurses, multiple simultaneous transitions as they enter the workforce including, but not limited to, personal, environmental, socio-cultural, and role-based transitions. Role transition alone—the progression from student to RN—has been coined “transition shock” (Boychuk Duchscher, 2009). The theory of transition shock explains that NL RNs face an abundance of shifting physical, emotional, socio-developmental, cultural, and intellectual changes that contribute to feelings of extreme loss, doubt, confusion, and disorientation upon initial entry into clinical practice (Boychuk Duchscher, 2009). These transitional changes are further complicated for NL RNs by fluctuating personal and professional

roles, relationships, and responsibilities (Schoessler & Waldo, 2006a), as well as a new sense of accountability different from what they experienced during their academic programs (Boychuk Duchscher, 2009). As a result, NL RNs frequently characterize their transitions to clinical practice as anxiety producing, stressful, overwhelming, discouraging, frustrating, disillusioning, and shocking (Boychuk-Duchscher, 2009; Dyess & Sherman, 2009; Hofler, 2008; Romyn, Linton, Giblin, Hendrickson, Limacher, Murray, et al., 2009; Smith, 2004; Wolff, Regan, Pesut, & Black, 2010b). This tumultuous passage from new graduate nurse to competent professional RN has been attributed to an academic-practice gap (Myers, Reidy, French, McHale, Chisholm, & Griffin, 2010; Romyn et al., 2009) that has left NL RNs underprepared to negotiate the nuances of acute patient care situations in rapidly changing, high-tech, complex, chaotic, and sometimes hostile environments (Dyess & Sherman, 2009).

Common features of post-licensure TTP for new nurses include challenges with supervision and delegation, less than ideal communication with interprofessional team members, unsupportive and unkind nurse colleagues, lack of time and/or opportunity to think through critical decisions, confusion upon receipt of contradictory practice-related information from peers, and an overall feeling of professional isolation (Boychuk Duchscher, 2009; Myers et al., 2010; Romyn et al., 2009; Wolff, Pesut, Regan, 2010a). Despite what is known about the challenges of TTP for NL RNs; there is little agreement on what constitutes best practice in facilitating their transition to practice and retaining them in the workforce.

At this time it is unknown if the TTP experiences of the typical new graduate nurse cohort reflect similarly the experiences of those with LDs. Thus, it is unclear how individuals with LDs navigate, negotiate, and experience TTP upon licensure. It is also unknown if persons with LDs disclose their LD and support needs to their workplace preceptors during their senior year preceptorship and/or upon hire. For those who disclose, it is unknown what their experience is in doing so. Furthermore, pre-transition planning, NCLEX testing, job acquisition, role-formation, vocational perceptions, and future career intentions for this group have yet to be explored in the context of the lived experience of LD at the intersection of nursing education and practice.

Consequences of TTP failure.

Given current and projected nursing shortage indicators, retention of NL RNs in the workforce is a dire concern. Despite the recent economic downturn in the United States, the demand for nurses continues to grow. It is projected that 581,500 new RN positions will be created through 2018, equivalent to a 22% increase in the current nursing workforce (American Association of Colleges of Nursing [AACN], 2012; Buerhaus, Staiger, & Auerbach 2009). Applying local data estimates, more than 14,000 of these positions will be filled by NL RNs with documented disabilities, and 7,000 or more by NL RNs with LD. It is estimated that 33-61% of all new RNs leave their initial place of employment within their first year of practice (Boychuk Duchscher, 2009), and 20% leave the profession completely within three years of graduating from their nursing programs (Romyn, et al., 2009). This is an alarming

rate of attrition that contributes a significant financial burden for organizations employing nurses.

The average cost to replace just one nurse employed on a medical-surgical ward is \$92,442 (Kennedy, Nichols, Halamek, & Arafah, 2012). This figure increases to \$145,000 when a nurse, upon completion of workplace orientation, vacates a position in a specialty area like intensive care, emergency services, or the operating room (Kennedy et al., 2012). Thus, the financial risk of recruiting, hiring, training, and then not retaining 7,000 new nurses with LD is upwards of \$650,000,000 for just those with documented LD entering medical-surgical units post-licensure. Sadly, these attrition rates are compounded by the current negative tone of the RN workforce. Approximately 50% of practicing RNs do not recommend nursing as a career option, and 25% actively discourage others from choosing it as a profession (Boychuk Duchsher, 2009). RNs report insufficient staffing as a primary factor that has raised nurses' stress, impacted their job satisfaction, and driven many to leave the profession (Buerhaus et al., 2009). Moreover, the additive effects of a dispirited RN workforce and the complexities of TTP leave many NL RNs disillusioned with their new roles.

At this time, it is unknown if/or how these workplace factors affect or not the experience of persons with LD, including their career aspirations and intentions, employment satisfaction, and retention outcomes. Notwithstanding, given the growing population of NL RNs with LDs, identifying preparatory strategies and conditions that support the successful pre- and post-licensure TTP of this group represents a critical contribution to current retention efforts. As current nursing school

enrollment figures are insufficient to meet projected demands for RN services, retention of all NL RNs is a national priority (AACN, 2012).

Nursing profession and disability.

Today, within nursing, philosophical differences are beginning to emerge among nursing professionals, their practice partners, and even nursing students regarding what it takes to be a nurse and the path by which one needs to progress to become a nurse (Bohne, 2004; Magilvy & Mitchell, 1995; National League for Nursing [NLN], 2011). At present there exists only a one-way track to the nursing profession; that is, licensure via an educational model that assumes and expects future nurses to possess the skills necessary to function as a generalist nurse across settings, including acute care. For the purposes of this research, it is argued that the image of the nurse - what a nurse is and ought to be capable of doing - has its roots in certain values and traditions held by the profession that are not only exclusionary, but are also outdated (Bohne, 2004). Fueling this concern is the re-design of healthcare delivery systems, the development of specialty practice organizations, newly emerging RN roles, and the documented need to expand and diversify the RN workforce (NLN, 2011). These factors together have prompted an implicit call for creativity and innovation in the formation of new conceptions of the NL RN (Institute of Medicine [IOM], 2010). I argue here that any new image of the nurse ought to consider the inclusion of those with LD who aspire to contribute to the profession and perhaps via a non-traditional path. Hence, this research will also critically examine the profession's assumptions and underlying driving values, attitudes, and traditions

that have created a culture of exclusion for many (including those with LD) within nursing academia and practice.

Significance to Nursing

This study was the first to explore and describe what pre- and post-licensure TTP is like for persons with LDs from the perspective of those living it. Because nursing has traditionally observed, described, counted, and commonly pathologised persons with LDs (Walmsley, 2001), this study intended to ask these individuals for their own insights and views about their experiences. A life history approach was best suited to explore LD diagnosis as a critical turning point, capture its meaning, and uncover its influence (if any) on participants' TTP experiences in nursing.

At present, scant research exists on nursing students and nurses with LDs, and prior to this study, no research existed on their TTP experiences and/or preparatory practices pre- and post-licensure. Thus, this research informs nurse educators in both academia and practice of the current state of pre- and post-licensure TTP as experienced by both student nurses and NL RNs with LDs, including the conditions and strategies that impede and/or promote this group's pre- and post-licensure TTP, employment outcomes, and access to and inclusion within the nursing profession.

Given that a label of LD carries with it a certain stigma brought about by societal misperceptions and prejudices, overt and/or covert discrimination of those so labeled is unfortunately commonplace. Therefore, I anticipated that the life histories of those with LD might be embedded with elements of marginalization or vulnerability that influence and impact their TTP experiences in nursing. I also assumed that such stories would shed light on both historical and present-day

institutional or societal structures and forces that might impede the TTP experiences of those with LD. Illumination of such insights will provide a space for the deconstruction of current nursing-specific TTP norms and their subsequent reconceptualization, thereby alleviating oppression of this group and promoting their inclusion and acceptance within the profession.

The results of this research offer a foundation and direction for future interventional studies and/or program evaluation aimed at promoting the inclusion, career success, and retention of persons with LDs within nursing. Importantly, this work will fuel ongoing discourse within the profession toward a much needed paradigm shift that prompts creative interventional strategies extending the possibility of alternative, more accessible, and inclusive pathways to nursing.

Specific Aims

A critical interpretive study using a narrative life history approach was implemented to explore and re-present the storied lives of this group. The aims of this study included:

1. Describe the situated experiences of individuals with LDs in transition to nursing practice (TTP) pre- and post-licensure.
2. Examine the identities and belief systems embedded in the life histories of individuals with LDs that may contribute to inequities within their pre- and post-licensure TTP experiences in nursing.

Chapter 2: Literature Review

Introduction

This review draws on the theoretical and research literature to explore five main areas including disability theory; authentic practice environments; transition to practice (TTP); impact of learning disability (LD) on transition; and relevant nursing research.

Construction of Normalcy

To understand disability requires a brief review of the construction of normalcy. The ideal of normal first presented in English consciousness between 1840 and 1860 (Davis, 1997). It has its roots in statistical science – the bell curve, the notion of mean or average, deviations from a specified norm, and extremes. Interestingly, Sir Francis Galton, Karl Pearson, and Alexander Graham Bell, the original promoters of statistical science, had interests in both eugenics and Darwinism (Davis, 1997). Thus, that which deviated from the norm, or did not keep pace with the norm, was targeted for elimination or thought to eventually succumb to processes of natural selection. This idea of normativity created the notion of ‘otherness’ within societies (Davis, 1997; Goodley, 2001). The construction of normal, the societal ideal upon which individuals are compared, has marginalized persons with disabilities and subjected them to prejudice and discrimination, like other persons differentiated from the majority by their race, ethnicity, sexual orientation, gender identity, or other unique characteristics (Davis, 1997).

Models of Disability

There are several paradigms of thought on disability. This section provides a brief overview of three primary models of disability most often reflected within the disability- or sociology-related literature. These include the medical model, the social model, and the disability studies model.

Medical model.

The medical model of disability subscribes to a hegemonic belief in normalcy. From this stance, disability is thought to be abnormal and equivalent to functional impairment (Oliver, 1996). Considered to be pathology or a deviance based upon an empirically founded norm, those who favor the medical model perceive disability as a personal tragedy for the disabled individual, and a problem to be solved, cured, or eradicated (Brisenden, 1986, Dewsbury, Clarke, Randall, Rouncefield, & Sommerville, 2004; Goodley, 2001). As such, those with disabilities are positioned within the sick role, lacking in some way, and thought to be incapable of fully participating in society or social life (Brisenden, 1986; Oliver, 1996). Given this perspective, medical treatment or rehabilitation therapy are prescribed to promote normality or an acceptance of the condition of disability and its perceived human limitations (Brisenden, 1986; Oliver, 1996). In this model, there is an obvious privileging of professional disciplinary paternalism over that of the lived experience of persons with disabilities (Brisenden, 1986; Oliver, 1996).

In general, nursing's perspective on LDs is relatively congruent with that of the medical model. The discourse within the nursing literature related to students with LD strongly suggests faculty hold an essentialist image of the ideal nursing student. If

students do not fit their instructors' prescribed mold, then they are sent for psychological or technical testing and assessment (Bradshaw & Salzer, 2003; Selekman, 2002; Shellenbarger, 1993) of an assumed pathology. Moreover, when a student fails a course or is dismissed from a nursing program, the blame is generally directed toward the student. Thus, academic instructors frequently perceive learning difficulties or disabilities to rest within the individual student. Specifically, LD is assumed a neurological problem resting in the heads of students who struggle to learn (Dudley-Marling, 2004). Hence, nursing has typically problematized students with learning difficulties, viewing them as abnormal or deviant, evidenced by their poor grades and/or the manifestation of maladaptive learning behavior(s) presenting in the classroom or clinical setting.

Social model.

Alternatively, the social model of disability suggests disability is socially constructed (Dewsbury et al., 2004). The model differentiates impairment and disability and positions the individual within a disabling social world (Shakespeare, 2006). In other words, society or the environment is to blame for disablism. Subscribers of the social model view disability within a socio-political framework that repositions persons with disabilities as citizens with certain rights, specifically the right to physical and cognitive access to all things within main steam that potentiate a purposeful and fulfilled life (Oliver, 1996). The social model:

“... does not deny the problem of disability but locates it squarely within society. It is not individual limitations, of whatever kind, which are the cause of the problem but society's failure to provide appropriate services and

adequately ensure the needs of disabled people are fully taken into account in its social organisation.” (Oliver, 1996, p. 32)

In terms of LD, this model suggests that students are not at fault for their learning struggles; rather, the environment is to blame (Oliver, 1996). Learning is perceived inaccessible due to inequities created by pedagogical flaws, including the delivery and evaluation of instruction, and other environmental features of the learning experience that disadvantage unique learners (Dudley-Marling, 2004).

There is much debate regarding this conceptualization of disability. In fact, some have deemed the social model to be ‘anti-social’ through its privileging of the experience of disability over that of medical-professional knowledge (Dewsbury et al., 2004; Shakespeare, 2006). Moreover, repositioning disability as a social problem rather than locating it within individuals can “. . . leave the ordinary practical business of getting on with one’s life unattended to” (Dewsbury et al., 2004).

Disability studies model.

The disability studies model expands upon the social model to present a broader view of the experience of disability. The model presumes persons with disabilities are “. . . complexly embodied historical actors embedded within social, economic, physiological, and political forces that shape, and often constrain, their lived realities” (Society for Disability Studies, 2012). Believers of this model see persons with disabilities situated at the intersection of local and global histories, systems, and structures (Ingstad & Whyte, 2007). As such, persons with disabilities are subject to ever-changing landscapes of disability experience inclusive of a variety of shifting social, cultural, and built environments (Ingstad & Whyte, 2007). In other

words, the model assumes disability is embedded within social and historical contexts, and it cannot be isolated from the many human relations through which it emerges (Society for Disability Studies, 2012).

In terms of LD, “The primary argument developed here is that one cannot be learning disabled on one’s own. It takes a complex system of interactions performed in just the right way, at the right time, on the stage we call school to make a learning disability” (Dudley-Marling, 2004). For example, dyslexia, a type of specific LD involving written language processing, can only ever exist in a context where visual literacy is the dominant form of discourse (Collinson & Penketh, 2010; Denhart, 2008).

Study Framework

I conducted this research through a disability studies lens. Thus, in contrast to the hegemonic paradigm of medicine, I assumed LD constructed and performed within specific historical, cultural, political, and social contexts. In other words, the presence of LD requires both the existence of others who do not have learning difficulties and a shared activity that illuminates and makes salient individual differences (Dudley-Marling, 2004).

Applying this lens, I assumed disability to be a part of all human experience, as well as “. . . (a) socially constructed; (b) part of normal human variation; and (c) requiring voice to deconstruct it” (Denhart, 2008, p. 484). A motivating force behind application of these ideas was to bring forth and confront political and institutional ideologies driving the values, attitudes, and assumptions actively creating disability within culture and society (Denhart, 2008) – and specifically within the nursing

profession. Thus, as a political act this research attempts to reposition the voice of those historically silenced in an effort to alleviate or eliminate oppression of those labeled as learning disabled (Walmsley, 2001).

Authentic Practice Environments (APEs)

To understand the intersection of LD and pre- and post-licensure TTP expectations and requirements, it is first relevant to present a basic overview of APEs including: definition; contextual features; academic-practice gap; APE conditions; and the specific clinical transitions that are a focus in this research.

Definition.

For purposes of this research, I defined APE as any real-life clinical setting where practicing RNs carry out their professional role obligations in real-time through dynamic interpersonal transactions. Though nursing students are exposed to a vast array of learning environments during their schooling including the classroom, skills laboratory, simulation, and multiple diverse clinical placements, the APE is the most complex and often challenging for them (Koontz, Mallory, Burns, Chapman, 2010). The same is also true for NL RNs. They generally experience a variety of learning environments upon employment including classroom or online settings, skills labs, simulations, and are also expected to immerse themselves as active learners in their chosen workplace (Park & Jones, 2010). Although the experience of learning and working in an APE may be familiar to NL RNs, the added pressure of self-regulation, accountability, and RN role obligation brought about by licensure itself creates an added layer of stress for many new graduate nurses while attempting to learn within the workplace (Boychuk Duchscher, 2009).

Contextual features of APEs.

There are many complex contextual features of APEs that make for challenges in learning in these settings (Boychuk Duchscher, 2009; Schoessler & Waldo, 2006a). As such, there is some debate about whether or not APEs are the best teaching-learning forums for promoting RN role development (Grealish & Trevitt, 2005; (Myrick, 2002). Workplace hierarchies and authoritarian directives stand counter to the teaching practices of many nursing programs (Grealish & Trevitt, 2005). Also, the APE is generally focused on service; therefore, many organizations are more interested in what learners can contribute to the work rather than their educational goals (Hughes in Grealish & Trevitt, 2005; Romyn et al., 2009). Learning in APEs can be erratic and overwhelming for learners, especially when efficiency in task completion is prioritized over students' developmental goals in demonstrating best practice (Boychuk Duchscher, 2009; Grealish & Trevitt, 2005). Notwithstanding, politics, pressures of working in inadequately funded and resourced institutions, resultant negative effects on work teams, the development of hierarchies, and the devaluing of nursing work in relation to medical work are hurdles that also intersect learning within APEs (Boychuk Duchscher, 2009; Grealish & Trevitt, 2005).

Academic-practice gap.

The purpose of using APEs is to allow learners the opportunity to apply their theoretical knowledge and practice skills in real-life clinical situations under the guidance of nursing faculty and/or staff nurse preceptors. However, the incongruence existing between the ideals of nursing taught in school and the realities of practicing within APEs reflect what is commonly referred to as the academic-practice gap

(Boychuk Duchscher, 2009; Dear & Keen, 1982; Harwood, 2011; Romyn et al., 2009; Wolff et al., 2010a; Wolff et al., 2010b). Here, learners struggle with implementing practice and often fail to carry out what they have been taught in school (Grealish & Trevitt, 2005). Because most nursing programs emphasize reflective practice and the importance of self-evaluation, learners within APEs often experience profound shock and moral discontent when failures in implementing nursing practice occur (Grealish & Trevitt, 2005; Romyn et al., 2009). Feeling pressured to assimilate to norms and established practices of the APE, especially when they run counter to nursing's professional standards and ethical commitments, further compounds learners' moral dissonance in these settings (Boychuk Duchscher, 2009; Grealish & Trevitt, 2005).

A primary factor fueling the academic-practice gap seems to be a lack of collaboration between nursing faculty and their practice partners in developing APEs that value openness to challenge and change and provide an opportunity for students, new nurses, and others to raise questions about observed practices (Grealish & Trevitt, 2005). Unfortunately, neither nursing faculty nor their practice partners appears to be claiming primary responsibility for creating this type of learning space (Grealish & Trevitt, 2005; Romyn et al., 2009). As such, many APEs are potentially unsupportive and/or threatening toward newcomers. Moreover, settings that discourage openness, inquiry, or trust bar learners from critically evaluating their practice as they have been encouraged to do while in nursing school (Myrick, 2002). Findings from Grealish and Trevitt's discourse analysis (2005) indicated that learners use certain coping mechanisms to reconcile practice-related inconsistencies. Within

APEs, learners create provisional theories and adopt new meanings about practice incongruent with what they previously learned via their nursing programs. Therefore the experience of learning or working in the APE can prompt the development of learners' nursing identity through an uncritical embodiment of practice work (Grealish & Trevitt, 2005). This is a much different kind of formation process than that encouraged in the academic setting where students are taught to critically question practice and justify their actions with current evidence (Grealish & Trevitt, 2005).

The requirements and expectations of learning in practice are often a surprise to those in pursuit of becoming nurses. For students, frequently changing clinical placements that offer only minimal opportunities for hands-on experience (Koontz et al., 2010; Romyn et al., 2009), and the lack of choice in selection of their pre-licensure APE placements (Ralph, Walker, & Wimmer, 2009; Yonge & Myrick, 2004) contribute to the unsettling experience of being a learner-worker in an APE. Additional factors that limit learners' reconciliation of the academic-practice gap include unskilled or inexperienced faculty and/or preceptors, lack of available career planning, and limited pre- and/or post-licensure job placement preparation (Casey, Fink, Jaynes, Campbell, Cook, & Wilson, 2011).

APE conditions.

Since learning progression is necessary for role mastery, the learning experience ultimately contributes to learners' transition success. There are numerous conditions of APEs that can impact and even halt the learning progress of students and/or new nurses. The nursing literature suggests that learning within APEs is highly

dependent on the experience of faculty and/or preceptors and the motivation of learners. Thus, faculty and preceptors' personal teaching strategies (e.g. controlling vs. collaborative teaching style and/or communication preferences) and their alignment (or not) with learners' characteristics affect the learning process (Ralph et al., 2009; Wieland et al., 2007). Other specific conditions that facilitate and/or impede learning in APEs include: support and inclusiveness extended by faculty and/or preceptors (Ralph et al., 2009; Wieland et al., 2007); number of preceptors used (Kim, 2007; Wieland et al., 2007); physicality of the work and number of competing learner commitments (Wieland et al., 2007); availability of adjunct structured learning opportunities (Watt et al., 2011); time allotted for both learning and accomplishing the work (Ralph et al., 2009); culture of the practice community (Grealish & Trevitt, 2005); extent of learner socialization within the APE (Harwood, 2011); and learner-preceptor preparation for the experience (Ralph et al., 2009; Yonge & Myrick, 2004).

Clinical Learning Transitions

Learners experience multiple transitions between differing APEs as they progress through their programs of study and eventually assume formal RN roles post-licensure. According to transition theory (Meleis, 2010), these frequently changing scenes within nursing are critical events for students and new nurses that prompt changes in their self-concepts as well as other individuals and/or environments. Transitions experienced while immersed in various APEs are both a process and outcome of complex person-environment interactions (Meleis, 2010). Time is a specific feature of these transitions (Meleis, 2010), as they usually begin at

the first anticipation of entry to a new practice arena and last until stability is achieved within the setting (e.g. perceived well-being). Though the transition of the learner toward RN role mastery is ongoing, the experience of movement toward this end is bound by certain phenomena in time (Meleis, 2010). The transitions learners' experience on their journey toward becoming competent practicing RNs, entering and exiting multiple APEs, are also subjective and dependent on their individual perceptions, prior experiences, and responses to role ambiguity or threatened self-concept (Meleis, 2010).

Furthermore, the stability of the environments where transitions occur is a factor in how they are experienced by learners (Ingstad & Whyte, 2007; Meleis, 2010). There exists a tension within APEs between the priorities of learning versus that of meeting patient care demands (Hughes in Grealish & Trevitt, 2005; Romyn et al., 2009). This tension is a factor of the student-learner to learner-worker transition, and contributes to added difficulty and confusion for all involved in the experience (Koontz et al., 2010). Additional factors affecting the stability of the APE may include, but are not limited to: the leadership of the unit, organization, or community; the experience level of licensed nurses and other staff members in the setting; staffing levels; patient assignment load or acuity index; tolerance for new learners in the setting; and interprofessional dynamics (Boychuk Duchscher, 2009; Dyess & Sherman, 2009).

Other conditions affecting the transition experience related to the APE include personal meanings, expectations; level of knowledge/skill, available resources, level of engagement in the process and planning, and emotional and physical readiness

(Meleis, 2010). Ultimately, a successful transition is typically characterized as a subjective sense of well-being, role mastery (comfort in performing the behaviors required in the new situation), and relational well-being with family, peers, and larger social networks (Meleis, 2010).

For the current study, I focused on three notable TTP experiences. These included: (1) students' first acute-care TTP experience, (2) their preceptorship TTP, and (3) their post-licensure TTP experience.

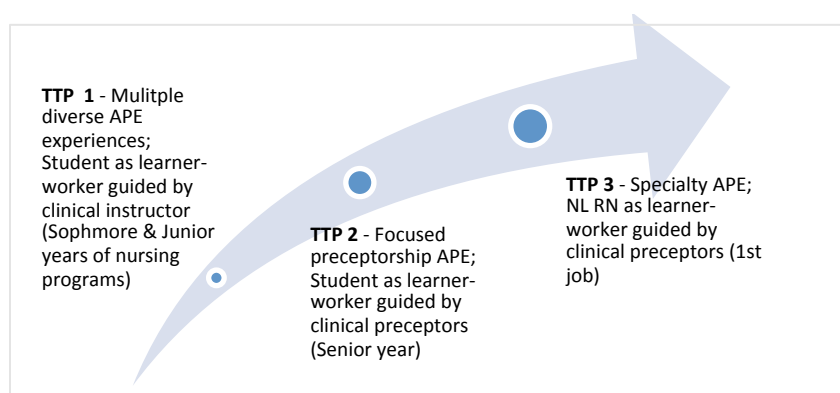


Figure 1. TTP experiences of interest

Transition to practice 1 – The experience of multiple and diverse APEs.

Within traditional nursing programs, students are generally exposed to three to five APEs during each year of their program, and they spend limited time (usually four to 10 weeks and between one to three days per week) in each assigned placement. APEs experienced by students during their nursing programs may include, but are not limited to hospitals, ambulatory care facilities, community agencies, hospice centers, homecare, addiction treatment facilities, jails, public schools, and more. In these settings, “Attitudes, work ethics, staff members, unit environment, equipment and supplies, census, and patients and family members are elements of the APE that cannot be controlled by instructors” (Koontz et al., 2010). Thus, the chaos,

complexity, and lack of control around learning within an APE may be initially shocking for many students upon entry to these setting. Specifically, Koontz et al. (2010) proposed that students' role change from *student-learner* in the classroom to *student-learner-worker* within the APE is a confusing transition for both students and staff members in these settings. In their qualitative descriptive study ($N = 10$), Koontz et al. (2010) identified both positive and negative factors that influenced student learning within the APE. Factors noted to positively impact learning included welcoming and inclusive attitudes demonstrated by the healthcare team, regular interactions with nurses who appreciated the opportunity to teach students about their practice, and environments that encouraged sharing of diverse perspectives on practice (Koontz et al., 2010). Feeling like a burden to staff nurses, the lack of opportunity to practice specific psychomotor/technical skills, and the variation in teaching practices as well as the clinical practices of staff nurses, were from students' perspectives negative aspects of their clinical learning experience (Koontz et al., 2010).

Transition to practice 2 – The focused preceptorship APE.

When students progress into the senior year of their programs, they typically participate in a preceptorship - also known as a clinical capstone or integrative practicum. This learning experience is an opportunity for students to spend a significant amount of focused time in a single APE with designated preceptor(s) (Spencer-Laschinger & MacMaster, 1992; Wieland et al., 2007). Preceptorships are generally designed to offer students the clinical space to apply knowledge learned in their program of study to real-life situations, thus theoretically enhancing their prior

learning (Byrd, Hood, & Youtsey, 1997; Rebeschgi & Aronson, 2009; Yonge & Trojan, 1992). Preceptorships have been used as a clinical teaching strategy for more than 30 years (DeWolfe et al., 2010). They vary in their structure and requirements based on program of study and/or state board of nursing regulations (DeWolfe et al., 2010). They also tend to be time-limited, defined by either number of weeks, ranging from three to 14 weeks, or required student hours, ranging from 72 to 340 hours.

A breadth of information exists on the importance of the preceptor-learner relationship toward bridging the academic-practice gap (Byrd et al., 1997; Casey et al., 2011; DeWolfe et al., 2010; Koontz et al., 2010; Myrick, 2002; Ralph et al., 2009; Wieland et al., 2007; Yonge & Myrick, 2004). Essentially, preceptors help learners understand how theoretical learning is applied within the context of everyday practice. Wieland et al. (2007) stated that the primary role of the preceptor is to “...ease new nurses through the honeymoon, shock, and recovery phases [of this transition] into the resolution phase and help them identify with positive professional behaviors and develop a balanced perspective on health care settings” (p. 316).

The preceptorship is also an opportunity for students to learn more about the everyday work of nurses in a specialty area of clinical practice. Thus, this experience helps students chart their future course in nursing – either toward or away from a specific area of practice as a result of their evolving self-conceptualization and identity formation related to nursing. It is a pivotal experience for many students that often positions them for employment post-licensure in the same or similar type of work environment as experienced during their preceptorship. In fact, 27 to 41% of senior students start their careers in nursing in the same APE where they completed

their preceptorship (Rebeschi & Aronson, 2009). Students also seem to be well aware that their preceptorship is an opportunity to explore potential employment possibilities within a specific APE. Thrysoe, Hounsgaard, Dohn, and Wagner (2011) found via a longitudinal interpretive study ($N = 9$) that during preceptorship students tended to be preoccupied with obtaining a first job as RN and were well aware others were assessing their performance to determine if they were a fit for the unit/agency. Post-licensure, the same students indicated that good learning experiences and the opportunity to demonstrate independence during specific clinical placements while in school, including preceptorship, were reasons for their first job choice (Thryose et al., 2011). Furthermore, these new nurses reported that peer referrals and experiences, as well as learning about the satisfaction of other NL RNs in the workplace were additional factors involved in the selection of their first jobs (Thryose et al., 2011).

Transition to practice 3 – APE upon first job as NL RN.

The majority of new graduate nurses often seeks and finds their first RN positions within the acute care arena (or hospital-based APE). Thus, the acute care setting has been of primary interest to nurse researchers studying post-licensure TTP. As such, several scholars have documented the challenges of TTP for new nurses entering acute care settings (Dyess & Sherman, 2009; Boychuk Duchsher, 2009; Harwood, 2011; Marcum & West, 2004; Park & Jones, 2010; Romyn et al., 2009; Schoessler & Waldo, 2006a; Schoessler & Waldo, 2006b). When new nurses enter their first jobs and new APEs, their learning experience drastically changes from one of organization, structure, and compartmentalized activities directed by their clinical faculty to the real world of self-directed *learning to be a nurse* in all its chaos and

complexity. The acute care APE is one of the most complex for new nurses in terms of their role requirements. In these settings, clinical staffs are faced with taxing workloads, chronic staff shortages, high patient acuity levels, hierarchy and power differentials, as well as constant changes and advances in knowledge and technologies that impact their day-to-day workflows (Dyess & Sherman, 2009; Grealish & Trevitt, 2005; Marcum & West, 2004; Romyn et al., 2009).

Romyn et al. (2009) found via their qualitative study ($n = 14$ new graduates; $n = 133$ staff nurses, educators, and managers) that upon entry to practice, new nurses were offered minimal support in terms of learning within the workplace due to the erosion of both comprehensive orientation programs and the role of the clinical nurse educator. This is a consistent finding within the literature as nurses have frequently reported they are expected to “hit the ground running” (Harwood et al., 2011), accept assignments beyond their capabilities, and carry out their work with minimal support or supervision (Romyn et al., 2009; Thrysoe et al., 2011). As beginners, NL RNs have experienced negative staff attitudes from others and reported feeling burdensome to their new and more seasoned colleagues (Dyess & Sherman, 2009). Upon initial job entry, feelings of disillusionment and disappointment are commonplace sentiments among NL RNs (Boychuk Duchscher, 2009). This sense of reality shock is known to affect the motivation, productivity, and quality of patient care provided by new nurses (Romyn et al., 2009; Wolff et al., 2010b). Although NL RNs upon TTP encounter significant emotional ups and downs as they navigate the shock of real-life nursing, the literature suggests it can take new nurses approximately six to eighteen months to *settle in* to their new role (Boychuk Duchscher, 2009; Schoessler & Waldo, 2006a).

However, the journey to the point of feeling *settled in* is unmanageable for many. Thus, not surprisingly, approximately 33-61% of all new RNs leave their initial place of employment within their first year of practice (Boyчук Duchscher, 2009), and 20% leave the profession completely within just a few years of graduating from their nursing programs (Romyn et al., 2009). Thrysoe et al. (2011) confirmed this more recently, reporting one third of the participants (three of nine) in their study were contemplating leaving their first RN jobs in coming months due to role-related complexities, dissatisfaction with workplace conditions, and/or the lack of positive professional challenges.

Presently, there is a lack of agreement within the profession about best practice in fostering successful post-licensure transition to APEs. However, identifying strategies that reduce post-licensure attrition due to unmanageable TTP experiences is a priority within the profession (AACN, 2012; National Council of State Boards of Nursing [NCSBN], 2015). Park and Jones (2010) completed an integrative review ($N = 17$) of the retention strategies used to ease commonplace NL RN TTP difficulties. They found internships, residencies, preceptorships, and structured or extended orientations were common programs used to promote RN retention upon hire (Park & Jones, 2010). The length of these programs varied. Some lasted less than three months while others extended for up to one year (Park & Jones, 2010). Teaching strategies used within these programs were also diverse; however, most included both classroom and clinical learning experiences (Park & Jones, 2010). Overall, the review indicated that these types of programs generally produced positive results in terms of nurse confidence, competency, and retention (Park & Jones, 2010).

However, the authors recommended more research to determine program characteristics that promote retention rates, specifically the optimal duration of such program (Park & Jones, 2010).

Many organizations are quite concerned with the upfront costs of lengthy TTP programs, as their return on investment is not obvious for one to two years post implementation (Park & Jones, 2010). However, some organizations have reported cost-effectiveness gains from their one-year programs (Park & Jones, 2010). Such offerings make logical sense, as they are theoretically aligned with the TTP experiences of new nurses and their passage toward becoming competent in their practice (Park & Jones, 2010). One-year programs also make sense, because it generally takes new nurses between six and 18 months to reconcile and/or resolve their TTP experiences to a tolerable degree (Boychuk Duchscher, 2009; Schoessler & Waldo, 2006a).

Though many of these retention strategies are no doubt well intended and potentially transferrable, it seems little if any attention has been directed to individualizing programs to suit the needs of unique learners. Rather, most TTP programs for NL RNs are organization-centric, not necessarily learner-centric in terms of the content prescribed and the way in which it is delivered. An extreme example of this involves the one-size-fits-all program presently being considered at the national level. The NCSBN developed and presented a TTP Model for testing across multiple hospital sites (Spector, Blegen, Silvestre, Barnsteiner, Lynn, Ulrich et al., 2015). The first phase of this study was conducted across three states and included all newly licensed nurses hired in 105 hospitals between July 1 and September 30,

2011 (Spector et al., 2015). Hospitals were randomly assigned to either continue use of their current onboarding programs for NL RNs or to adopt the NCSBN Transition to Practice model program (Spector et al., 2015). NL RNs in these hospitals volunteered to participate in the study and completed surveys at baseline, six, nine, and 12 months. Survey data included error rates, safety practices, competence, work stress, and job satisfaction. Investigators collected retention data from all participating hospitals as well. Newly licensed nurses employed in the hospitals that adopted the NCSBN program were asked to complete five on-line instructional modules during the first three months of their employment. The modules contained content on patient-centered care, communication and teamwork, evidence-based practice, quality improvement, and informatics. In addition to online modules, participants were partnered with a preceptor in their APE for six months. To be involved in this study, preceptors were required to complete an online training module related to their role. During the last six months of their study participation, NL RN participants received institutional support to engage in organizational practice-oriented activities (NCSBN, 2015). This included invitation to serve on varying committees, review and/or develop policies and procedures, and participate in root cause analysis involving practice issues (NCSBN, 2015).

Investigators found that the NL RNs in the control group (hospitals with established TTP programs in existence for at least two years) reported better outcomes on all variables of interest over time including fewer errors, fewer negative safety practices, higher competence, less stress, more job satisfaction, and less attrition compared to those who were in the NCSBN TTP program (Spector et al.,

2015). Study investigators found that most hospital-based existing TTP programs were also evidence-based. Thus, nurses in both the control and experimental groups received similar content in the first year of their TTP programs. Since the content of the TTP programs was similar no matter group assignment, investigators attributed the difference in findings between the control and NCSBN TTP program to be a consequence of the newness of the NCSBN program (Spector et al., 2015). Notwithstanding, investigators provided very little information about the format of the content (e.g., print, audio, and/or simulation) and how it was delivered (e.g. online vs. face-to-face) in the hospitals with established TTP programs.

Though evidence suggests that TTP programs improve patient safety and quality outcomes, as well as job satisfaction, work stress, and retention rates among new nurses (Anderson, Hair, & Toderò, 2012; Spector, 2015; Theisen & Sandau, 2013), every program assumes certain learner strengths and puts some learners at a significant disadvantage. For example, the NCSBN TTP program requires NL RNs to be astute at online learning, reflective practice, reading/writing, and specific test-taking skills. In addition, the program does not consider preceptor-learner dynamics and matching of work-, communication-, and/or the learning-styles of these duos. Furthermore, the content and its delivery are directed by the NCSBN rather than following a baseline assessment of individual learners' knowledge, prior experiences, learning preferences, and unique learning needs.

Preparation for TTP

Within the nursing literature, preparation for pre-licensure TTP experiences has been addressed briefly, and specifically as related to the preceptorship experience.

Casey et al. (2011) found in their mixed-methods descriptive study ($N = 429$ BSN students) that learners' preparatory practices for preceptorship tended to vary based on individual faculty and preceptors' expectations. Learners in this study reported using self-initiated preparation activities including the provision of a medication reference text or digital assistant for the clinical setting, identification of daily goals with preceptors, engagement in relevant simulation or skills lab activities, and the development of care plans specific to daily clinical assignments (Casey et al., 2011).

Wieland et al. (2007), the only research team to date to consider preceptorship from a transitions perspective, defined preceptorship as "... a social and physical passage whereby students progress toward the role of graduate nurse" (p. 315). Their triangulated descriptive study sought to describe the preceptorship transition through the perceptions of their participants who included senior nursing students ($n = 32$), their preceptors ($n = 9$), and their clinical faculty ($n = 3$) (Wieland et al., 2007). They found that during the preceptorship students began to act like staff nurses assuming responsibility for time management, documentation, multiple assignments, and other expanded duties (Wieland et al., 2007). Participants in this study accomplished aspects of role-related transition by improving efficiency, organization, prioritization, and competency in their work over the duration of the preceptorship (Wieland et al., 2007). This study also illuminated quality improvement opportunities related to the preceptorship transition experience. These included ensuring consistent faculty and their presence in student learning in preceptorship APEs; facilitating student-preceptor relationships; maintaining a single preceptor per student; orienting both students and preceptors to the preceptorship course; clarifying evaluation guidelines

and responsibilities of students, preceptors, and faculty; and clearly defining the expectations of the course with students prior to its inception (Wieland et al., 2007).

Yonge and Myrick (2004) confirmed in their work similar preparatory issues related to preceptorship. They found via their mixed-methods study ($n = 75$ preceptors; $n = 52$ students) that almost half of both the preceptor and student groups felt ill-prepared for the preceptorship. Furthermore, 26% of the preceptor group believed some type of formal training would be beneficial to them given their role in the course.

DeWolfe et al. (2010) following their systematic review of the literature ($N = 47$) of preparation activities relevant to preceptorship recommended that nursing students could be better prepared for preceptorships via interventions that allow them to assess their own learning needs and develop learning goals and plans. Additionally, they suggested that preparation activities should ensure nursing students have the essential clinical, communication, and professional skills to simultaneously practice and learn in the preceptored setting (DeWolfe et al., 2010).

Given the dearth of literature on pre-licensure TTP preparation practices, it appears nursing has some additional work to do in this area. Furthermore, it is concerning that no studies to date have examined new graduates' pre-TTP planning or preparatory practices. This is a significant oversight given the attrition consequences of unmanageable TTP. Clearly there appears to be a mismatch between NL RNs expectations of TTP verses their actual TTP experience (perhaps due to a lack of preparation for this passage).

Given the limited amount of attention paid to pre-transition planning for students and new nurses, it is vitally important to note the implications of this for persons with LD entering this field. It is well-documented within the LD literature that managing transitions to new environments is particularly challenging for those with LD (Mellard, 2005; Siperstein, 1988; Skinner & Lindstrom, 2003), and preparation for transition has been identified as a key factor in promoting the successful educational and vocational outcomes of this group (Durlak, Rose, & Bursuck, 1994; Gregg, 2007; Janiga & Costenbader, 2002; Koller, 1994; Madaus et al., 2008a). Due to the lack of available theoretical and/or research-based information on preparation for pre-and/or post-licensure TTP in nursing, this topic remains in urgent need of further exploration and is of greater criticality today given the increasing numbers of students with LDs entering nursing programs (McCleary-Jones, 2008; Kolanko, 2003). Moreover, pre-transition planning and/or methods of formal preparation for TTP may not only be beneficial to those with LD, but could also assist the masses of new graduate nurses with reconciling their idealistic vision of what it is to be a nurse with the realities of navigating and negotiating working as a professional nurse in complex, chaotic, and sometimes hostile work settings.

Impact of Learning Disability

For persons with LD on a career path to nursing, the impact of disability is expected to vary between individuals. However, there are certain contributing factors that present in academia and/or the workplace related to the experience of disability that potentially influences its overall impact on individuals with LD. Most often these factors manifest as additional complexities and hurdles for many in achieving career

goals. These factors are discussed in the next section as organizational structures; intrinsic skills; self-identification, disclosure, and consequences; receiving a new LD diagnosis; accessing accommodations; and histories of failure.

Organizational structures.

U.S. law clearly supports the recruitment and inclusion of persons with LD (when qualified) into both educational programs and employment opportunities in nursing. The U.S. Rehabilitation Act of 1973 and Section 504 prohibits discrimination of persons with disabilities in educational processes endorsed financially by the federal government (e.g. public education, colleges, and universities). Though law does not require programs to lower their standards or implement special education tracks for students with disabilities, it does require institutions to be prepared to make appropriate academic adjustments and reasonable modifications to policies and practices to allow for full participation of students with disabilities.

The regulations of the U.S. Rehabilitation Act, Section 504 formed the basis of the Americans with Disabilities Act (ADA), signed into law on July 26, 1990 and amended (ADAA) in 2008. The ADAA (2008) is a comprehensive mandate that prohibits discrimination against Americans with physical and mental disabilities, and requires equal opportunity be extended to qualified individuals. Here, a qualified individual is defined as one who, with or without reasonable accommodations, can perform all of the essential functions of a specified position. And, the term, *essential functions*, refers to the required minimum duties and abilities needed to perform the tasks of a specified job. Essentially the ADAA (2008) limits educational institutions'

or employers' defense against discrimination claims. Unless a person with a disability presents as a significant risk to the health or safety of others, or accommodating the qualified individual imposes undue operational hardships (i.e., excessive financial burden), institutions and employers are obligated to provide the adjustments necessary to support the functioning of qualified individuals within their environments.

Unfortunately, the organizational structures and related disability laws governing secondary institutions poorly position students with LD to self-manage their rights under the ADAA upon entry to their post-secondary programs (Gerber, 2009; Gregg, 2007). To understand this predicament, it is important to first note that primary and secondary-level schools are held accountable for ensuring students' educational success as per the Individuals with Disabilities Education Improvement Act (IDEA) of 2004 (Gerber, 2009; Madaus, 2005). This means that secondary schools are obligated to identify when a child or adolescent requires academic support, offer necessary testing, provide accessible learning opportunities, and create conditions that support students' successful post-school transition and achievement of future goals (Gerber, 2009; Madaus, 2005).

IDEA (2004) further requires the development of an Individualized Educational Program (IEP) for students with LD (Gerber, 2009). The IEP is intended as a pre-transition planning tool, and as such must include plans or procedures for identification of appropriate employment, additional education, and other post-school adult living objectives for the student (Gerber, 2009). Typically, parents are actively involved with school officials in the development of the IEP (Mellard, 2005). There is

evidence, however, that students may not be participatory in this process (Trainor, 2005; Trainor, 2007), and this may be a factor that does not serve them well in their post-secondary educational pursuits (Mellard, 2005).

To facilitate student transitions between high schools and post-secondary educational institutions, the IDEA (2004) mandated the Summary of Performance (SOP) for completion by high school educators. Essentially, the SOP is intended to provide a wide variety of information to post-secondary officials who will work with students with LD in their settings (Gerber, 2009). Information in the SOP includes background assessment information; students' post-secondary goals; level of academic, cognitive, and functional performance; recommendations or accommodations; and student input (Gerber, 2009). If used wisely, the SOP can have a significant impact on the matriculation and retention of post-secondary students with LD. However, there are no statewide guidelines for use of the SOP, and most college officials are unaware of its existence (Gerber, 2009).

Though the IDEA (2004) and items like the IEP and SOP make good sense, they pose many issues for students with LD transitioning to college programs. These students upon college entry are no longer covered under IDEA regulations (Gerber, 2009; Madaus, 2005; Sitlington & Payne, 2004). Instead, they are subject to ADA law (Gerber, 2009; Madaus, 2005; Sitlington & Payne, 2004). This shift in legal protections for persons with LD upon entry to their post-secondary programs brings about a significant and unexpected role change for these students.

In their secondary institutions students' academic success was the primary responsibility of their schools. However, in post-secondary settings it is up to students

to initiate and manage disclosure processes, provide evidence of disability, and self-advocate for needed accommodations (Gerber, 2009; Madaus, 2005; Sitlington & Payne, 2004). Due to this situational and organizational transition, some students may not even be aware of their responsibility to disclose their learning difficulties and determine their own learning needs and necessary support.

Students transitioning to post-secondary programs are also subject to major disconnects between the rules and regulations of the IDEA (2004) and the ADAA (2008) (Gartland & Strosnider, 2007; Gregg, 2007; NJCLD, 2007; Madaus & Shaw, 2006; Sitlington & Payne, 2004). These disconnects involve inconsistencies in required disability documentation; the provision of access to certain programs and reasonable accommodations, disability assessment techniques, and transition services (NJCLD, 2007). For example, depending upon the policies and procedures of each post-secondary institution, students' prior disability assessment documentation (if available) is subject to expiration (NJCLD, 2007). Therefore, obtaining the required documentation for proof of disability can be a major hurdle for students upon entry to college.

Intrinsic skill.

The educational oversight provided by parents, counselors, and special educators in primary and secondary institutions can create in some cases a certain level of student dependency (Durlak et al., 1994; Mellard, 2005). Thus, students with LD may not have the skills of self-advocacy or self-determination to independently commence and navigate required post-secondary disability-related transactions. This is problematic, because these skills have consistently been confirmed within the LD

literature as essential to the educational and vocational success of this group (Durlak et al., 1994; Madaus et al., 2008a; Skinner & Lindstrom, 2003).

Gerber (2009) found via a review of the relevant literature on serving adults with disabilities that specific skills reflective of self-advocacy include: understanding of one's own disability as well as knowledge of disability law and legal rights, needed accommodations, and effective communication skills. Aspects of self-advocacy are interrelated with self-determination. Field, Martin, Miller, Ward, and Wehmeyer (1998) defined self-determination as follows:

Self-determination consists of a set of skills that enable a person to engage in goal-directed, self-regulated, autonomous behavior. An understanding of one's strengths and limitations together with a belief in oneself as capable and effective are essential to self-determination. When acting on the basis of these skills and attitudes, individuals have greater ability to take control of their lives and assume the role of successful adults in our society. (p. 2)

Students with sound self-determination skills essentially 'own' their LD. They can identify it and its impact in varying situations, and then act on it, manage it, or solve it (Gerber et al., 1992). To do this in education and the workplace requires a thorough understanding of disclosure processes and relevant protective laws. Goal setting and self-awareness have also been identified as key elements of self-determination promoting achievement of educational and career aspirations (Gerber, Ginsberg, & Reiff, 1992). In addition, practices of self-determination frequently involve reframing, or finding the positive side of disability and using one's strengths as a basis for action toward goal achievement. Interestingly, persons who demonstrate

self-determination often choose careers that reflect a good fit with their strengths and weaknesses (Gerber et al., 1992).

Given that students enter nursing with a career in mind, it could theoretically be assumed that typical nursing students have strong skills related to self-determination. However, this has yet to be studied as related to nursing students or nurses with LD. Although this is not a specific focus of the current study, it is anticipated participants' life histories may illuminate aspects relevant to concepts of self-advocacy and self-determination.

Self-identification, disclosure, and consequences.

Those who are self-determined may be better positioned to see the value in disclosure of LD. However, disclosure is a process of self-identification, and for a host of reasons identifying oneself as disabled is not something most people readily want to do. It has been well documented that a label of disability carries with it a stigma of being less than, abnormal, unable, inadequate, and/or other similar negative descriptors (Collinson & Penketh, 2010). Even when students self-identify as having a LD and have the sophistication and self-determination to initiate and manage their disability disclosure process, for them disclosure is not a finite experience, but rather reoccurring (Price et al., 2007). It is an anxiety-producing complex ordeal that repeats itself throughout students' educational programs and thereafter in the workplace (Price et al., 2007).

Because of the repetitive nature of disclosure, there are multiple opportunities for negative outcomes to occur. If persons with LD perceive or find rejection, stigma, or discrimination as a result of any one experience of disclosure, this may curb their

willingness to reveal their disability or request reasonable adjustments in future situations. Thus, disclosure remains a significant component, and in many cases an additional obstacle for students and new nurses with LD to manage during their TTP experiences.

There is some evidence within the LD literature that suggest that persons with LD rarely disclose their disability to their faculty (Skinner & Lindstrom, 2003) or workplace managers (Gerber et al., 2004; Madau et al., 2008b; Price et al., 2007). Disclosure of LD is not required of students in program admission processes for post-secondary programs (Dupler et al., 2012), nor for job entry (ADAA, 2008). However, students and job seekers must disclose their LD in order to be covered by ADAA protections (Dupler et al, 2012; Price et al., 2007). Commonly, this group is also required to provide evidence of their disability if they desire to request and receive reasonable adjustments that support their learning within their educational programs or workplace settings (ADAA, 2008; Dupler et al., 2012).

Though disclosure may seem inconsequential, negative attitudes of others (including faculty, peers, and workplace staff/managers) prohibit disclosure for many (Janiga & Costenbader, 2002). Persons with LD fear being harassed, mistreated, or discriminated against due to their specific learning needs (Dowrick et al., 2005). Within the nursing literature there is evidence that faculty lack knowledge about ADAA law and its implications relevant to their role in working with students with disabilities (May, 2014). There is also mixed evidence about the attitudes of nurses (including faculty and workplace supervisors) toward persons with disabilities

pursuing nursing careers (Colon, 1997; Maheady, 1999; Sowers & Smith, 2004; Wood & Marshall, 2010).

For example, Colon (1997) in a quantitative descriptive study exploring the recruitment, identification, accommodation, and success promoting strategies used within nursing programs to prepare students to sit for the NCLEX exam ($N = 37$ dean/nursing program directors), found nursing faculty to model aspects of caring toward persons with LD by creating inclusive learning environments. Conversely, Sowers and Smith (2004) in their quantitative descriptive study surveyed faculty about their perceptions, knowledge, and concerns regarding nursing students with disabilities ($N = 88$). They found faculty attitudes were a barrier to this group of students and their learning progression. Interestingly, faculty in their study also reported they were less positive about students with LD becoming nurses than students with physical disabilities (Sowers & Smith, 2004).

Participants ($N = 10$ students/new nurses) in Maheady's (1999) qualitative triangulated study confirmed experiencing widespread negative and pessimistic attitudes issued by faculty, peers, patients, and employers. These students also felt disclosure was a risk that resulted in negative consequences (Maheady, 1999). Wood and Marshall (2010) quantitatively surveyed nurse managers ($N = 219$) with the majority representing acute care settings. Eighty-three percent of participants indicated they worked with one or more nurses with disabilities (Wood & Marshall, 2010). Three percent of the nurses with disabilities in this study had LD, while the remainder were reported to have disabilities including addictions, physical disabilities, hearing impairments, visual impairments, speech impairments, mental

illness, epilepsy, and diabetic complications (Wood & Marshall, 2010). Although nurse manager concerns were not differentiated with respect to their staffs' types of disabilities or their severity, it is worth noting that just under half the nurse managers in this study reported high to severe concerns related to the abilities of staff nurses with disabilities to perform their job functions (Wood & Marshall, 2010). Additional areas of concern noted by nurse managers about staff nurses with disabilities included patient safety, productivity levels, quality of work, problem-solving skills, and academic abilities (Wood & Marshall, 2010). It is difficult to ascertain from this study where these types of concerns originated, however. Though 83% of participants in this study indicated they worked with one or more nurses with disabilities, it is unclear if survey data was based upon one encounter with a staff nurse with disability or more, and no comparison group was used. Thus, it is unknown if nurse managers had concerns in similar areas about staff nurses who did not identify as having disability. In addition, the voices of those with disabilities, specifically learning LDs are not accounted for, so their intentions are unknown with regard to safe practice.

Given perceived and actual negative consequences inherent in disclosure, many persons with LD prefer to hide the truth about their learning or support needs. This creates additional stress and tension for this group as well. Many are reluctant to ask for help, preferring instead to use avoidance strategies to hide their disabilities, or implement passing techniques – that is, behaviors that disguise their disability to some degree (Gerber et al., 1992). These personal strategies are often measures used to avoid disclosure (Gerber et al., 1992). Though it is plausible that avoidance strategies and passing techniques may have patient safety implications, nursing

students and RNs with LD as distinct groups have yet to be linked with medical errors or patient injury. Despite a pervasive misperception within the nursing profession, there are no studies confirming that persons with LD practicing in APEs are dangerous to the public or unsafe in their work (Griffiths, Worth, Scullard, & Gilbert, 2010).

While some persons with LD may intentionally attempt to hide their difficulties, others may simply maintain a certain hope or mindset that things will be different for them in new settings, and thus determine disclosure is not necessary (Skinner & Lindstrom, 2003). Though this strategy may prove effective for a select group, for many disclosure may arise secondary to other issues like compromised academic standing or inquiries initiated by colleagues or supervisors in the workplace related to irregular practice behaviors. Often when disclosure is prompted by someone else (faculty, peers, supervisors), it is frequently too late to implement adjustments that may have promoted more positive outcomes. This is particularly true within the academic setting. Once failing grades are issued, they are generally not retractable (Bradshaw & Salzer, 2003).

Receiving a new diagnosis of learning disability.

Not all college level students with LD are diagnosed prior to entering their post-secondary programs. In fact, more than 50 percent of post-secondary students with LD are diagnosed during their college years or thereafter (McCleary-Jones, 2008; Rosebraugh, 2000). In cases where LD may be undiagnosed yet suspected, faculty may refer students for educational testing (Selekman, 2002). The nursing literature recommends faculty refer students for educational testing when they notice

students to have difficulties with math, reading, written language, and/or auditory processing skills (Letizia, 1995). In the classroom setting, these concerns often become apparent when students have difficulty with understanding directions, following instructions, locating information in syllabi, and completing assignments on time (Bradshaw & Salzer, 2003; Selekman, 2002). Within the clinical setting, nurse educators have observed that students with LD often struggle with following verbal directions and prioritizing orders (Bradshaw & Salzer, 2003; Selekman, 2002; Tumminia & Weinfield, 1983); problem-solving, charting, communicating, observing, and responding during urgent situations (Selekman, 2002); and planning patient care, setting outcome goals, initiating and sustaining action, accepting and monitoring feedback, and retaining or applying relevant data to specific care situations (Bradshaw & Salzer, 2003).

Most often, such difficulties arising in either the classroom or clinical setting generally prompt a discussion between faculty and students (Shellenbarger, 1993; Bradshaw & Salzer, 2003). If students are unaware of any reason why they may be struggling to perform either academically or clinically, the nursing literature recommends that faculty direct students to contact their Student Access Services (SAS) representative to determine if educational testing is advised (Selekman, 2002). If students are referred for educational testing, an educational or developmental psychologist typically performs the testing for LD. Although there is little agreement with regard to specific testing measures for diagnosing LD, a combination is generally used, including: intelligence quotient (IQ) test; speech and language

assessments; perceptual-motor skills evaluation; and coordination and fine motor skills analysis (Shellenbarger, 1993).

Testing for LD can be a lengthy (Ridley, 2011) and an expensive process for students (Madaus & Shaw, 2006). Thus, the LD literature suggests that timely recognition of students who have learning difficulties is essential for the educational success of this group (Madaus & Shaw, 2006). Students have reported mixed emotions related to educational testing processes for LD, with some unfortunately reporting it to be a negative, impersonal, and dehumanizing experience (Denhart, 2008).

Accessing accommodations.

Once students have obtained and submitted required proof of disability documentation, they may request reasonable accommodations intended to support their learning. Students who were previously diagnosed with LD earlier in their lives may be aware of their unique learning needs and the academic accommodations that have fostered their success in past educational pursuits. However, students newly diagnosed may need added time to determine their needs. No matter the timing of disability diagnosis, nursing students with LD will likely have difficulty identifying reasonable accommodations helpful to them in the clinical setting or varying APEs. Typically this will be a process of discovery, as students will not know what they need to support their learning within the APE until certain situations arise (Dupler et al., 2012). Hence, as new situations emerge within APEs, students will first need time to assess their own learning and performance capabilities to determine if accommodations are necessary (Dupler et al., 2012).

Within nursing, some suggest that minimizing transitions between APEs (and thus the impact of disability-related factors like disclosure and accommodations) for students with LD is a strategy that may foster overall learning progression for this group (Griffiths et al., 2010). Minimizing transitions for students with LD may also reduce the number of disclosures they would otherwise need to make to faculty, disability services personnel, and other staff to gain accommodations. This is important as accommodation processes are repetitive for students, required term after term, and the disclosure process around accessing accommodations has consistently been characterized as “...frustrating, embarrassing, unpleasant, stigmatizing, and unending” for students with disabilities (Field, Sarver, & Shaw, 2003, p. 346).

The implementation of classroom accommodations has been heavily documented within the nursing literature (Colon, 1997; Eliason, 1992; Selekmán, 2002; Shellenbarger, 1993). The most common types made for nursing students with LD include the provision of note takers; a quiet room for test taking; extended assignment deadlines, double test-taking time; scheduled breaks; audio recording; and test readers (Letizia, 1995). Though these classroom accommodations are commonly called out in the literature, very little is known about their effectiveness and/or how they may or may not translate to the clinical practice setting. For example, it is unknown what a quiet room or double-time for test-taking means (if anything) in terms of performance in APEs.

Furthermore, limited information exists on the implementation of accommodations within APEs. Within the nursing literature, there is some evidence suggesting that clinical faculty and workplace staffs or managers lack the tolerance

and/or training to implement learning support needs in the APE even after they have been identified (Sanderson-Mann & McCandless, 2006). Fueling this situation is the proposition that nursing faculty are generally underprepared to teach students with unique learning needs, and many have never been exposed to disability studies content (Selekman, 2002). There are also prevalent misperceptions that accommodations provide students with LD some kind of advantage over other students (Field et al., 2003). However, the basic intent of accommodations is to provide students with disabilities a level playing field, not a competitive edge (ADAA, 2008).

Within nurses' workplace APEs, accommodations have primarily addressed the needs of nurses with physical disabilities (Ferguson, Evans, Hajduk, Jones, Liston, Myers, et al., 2009), though job modifications may also be applicable for persons with LD. Clinical accommodations have included adjustments in job duties and equipment; offering shorter shifts, flexible hours, or work from home options; and the revision of job descriptions to reflect more flexibility in required essential functions (i.e., lifting, performing resuscitation, medication administration, etc.) (Ferguson et al., 2009).

The LD literature suggests that employers generally lack knowledge when it comes to issues of disability, and they tend to hold negative perceptions and misunderstandings about disability (Copeland et al., 2010; Reiff in Madaus et al., 2008b). Copeland and colleagues (2010) via a quantitative study surveyed employers ($N = 142$) regarding their attitudes toward persons with disabilities in the workplace. They found that the more experience employers' had working with employees with

disabilities, the more positive their attitudes about providing reasonable accommodations to such employees. Thus, the investigators recommended that employers be exposed, informed, and educated on the benefits of hiring persons with disabilities; ADA law; and workplace accommodations.

Not only do nursing students with LD need to consider supportive accommodations relevant to the classroom and their practice settings, they also need to keep in mind potential accommodations needed for their post-graduation licensing exam, the NCLEX. The National Council for State Boards of Nursing (NCSBN) adheres to ADA law and specifications regarding disability determination and reasonable accommodations (Ijiri & Kudzma, 2000). If students with LD plan to seek accommodations for the NCLEX they have to provide documentation of disability as well as a description from their nursing school of modifications extended during the program in both the classroom and clinical settings (Ijiri & Kudzma, 2000). Disability diagnosis documentation must include history of the disability and accommodations use, scores and interpretation of standardized diagnostic tests (e.g., Weschler Adult Intelligence Scale, Woodcock-Johnson), and recommendations for testing accommodations with corresponding rationale (Ijiri & Kudzma, 2000). Although there is no empirical data on NCLEX failure rates of students with LD, they are thought to be at high risk (Hussey & Smith, 2010).

Histories of failure.

Persons with LD who are successful in education and/or their chosen vocations tend to have characteristics including intellectual ability (specifically reading and math achievement), involvement in extracurricular activities, and

resourcefulness in accessing assistive support services (Mellard, 2005). Having the ability to realistically adapt to life events; a sense of self-awareness of strengths and weaknesses related to LD; a proactive approach, motivation, goal-directedness; and a willingness to persevere in meeting goals are also characteristics associated with the successes of this group (Mellard, 2005).

Persons with LD who are successful in their educational and vocational pursuits are the exception. There are multiple reasons why this is the case. The LD literature suggests social support (like peers, family, faculty, employers, and supportive programming) is a primary contributing factor, and this group tends to have few friends and poor social skills (Mellard & Hazel, 1992). This situation combined with inadequate academic or job performance, and years of frustration, misunderstanding, and misinterpretation related to disability takes an emotional toll on persons with LD (Collinson & Penketh, 2010). For those labeled with LD, this kind of social dismissal generally results in low self-esteem, lack of confidence, and social isolation (Selekman, 2002).

Because this is the reality for many, transition failures can be especially devastating for persons with LD (Eliason, 1992). Failures not only compound self-deprecating attributions and learned helplessness, they also contribute to a vast array of emotional consequences for this group including overall poor self-concept, withdrawal, anxiety, depression, and other negative feelings and/or behaviors (Eliason, 1992). Given these effects, it is not surprising that up to 75% of adults with LD require mental health services as a result of the social, emotional, and the subsequent stigmatizing impact of LD (Eliason, 1992).

Consequently, the construction of LD, as it exists in the U.S. today has disadvantaged many in terms of realizing their potential and thus meeting their educational and vocational goals. Failures repeated over the lifetime of these individuals have contributed to poor educational and vocational outcomes for this group (Israelite, Swartz, Huynh, & Tocco 2005; Rojewski, 1999; Skinner & Lindstrom, 2003). Israelite and colleagues' (2005) qualitative descriptive study ($N = 9$ students and college graduates) captured the essence of the history of failures for persons with disabilities as related to transition from university to work. All participants in her study indicated a lack of self-confidence in searching for and maintaining a job. Specifically, comments from participants exemplified the impact of repeated life course failures:

You always have to question the self-esteem. You know, am I ready for this stuff [the workplace/job]? If you are rejected too many times, then you sometimes just fear rejection... you wonder, why should I put up myself for another failure? (p. 23)

Best practices in transition for persons with LD.

Within the LD literature, there has been some focus on improving the educational and vocational outcomes of this group by improving individual readiness for transition to post-secondary education and work environments. Siperstein (1988) proposed a comprehensive three-stage transition model for the delivery of support services to students with LD. Transitions within this model include: (1) entry to college, (2) management of academic and social changes, and (3) exit from college into job entry (Siperstein, 1988). The model proposes support services should start in

secondary school and ought to include encouraging students' college interests via the development of an individualized college plan (ICP). The ICP should then be carried over into the college program. Theoretically it is anticipated "...the ICP should provide students with strategies to plan for the different skill needs that may arise throughout the course of the college experience" (Siperstein, 1988, p. 433).

Siperstein (1988) recommended second phase support services include those that assist students with LD to manage the changes and challenges presented during the college experience. Suggested activities for this stage include: the effective delivery of support services, compensatory skill workshops focused on study skills and test-taking strategies, social functioning workshops inclusive of assertiveness training or stress management topics, student initiated projects like peer support groups or networking opportunities, and faculty workshops on learning disabilities and instructor responsibilities.

Third stage support services within Siperstein's model (1988) included career awareness workshops, job search strategies, and job maintenance skills. As well, the model proposed career-coaching services to assist students in making realistic career decisions via planning, self-assessment, job exploration, and job assessment activities. During this stage of transition, Siperstein (1988) posited students should have access to support services focused on professional resume building, writing cover letters, and interviewing. In terms of job maintenance, Siperstein (1988) recommended that supportive workshops be geared toward both students and alumni with LD, and that they cover goal setting, responding to employer feedback, interpersonal interactions, and job-related responsibilities.

Siperstein (1988) proposed that colleges supporting students via this kind of transition model will recognize benefits including increased enrollment of persons with LD in their college programs, reduction in student attrition/failure rate, and positive post-graduate employment outcomes that may further impact the financial viability of school programs via alumni support.

Other models or recommendations related to transition for persons with LD were uncovered via the LD literature; however, they examined only one aspect of transition, either from high school to college (Durlak et al., 1994; Field et al., 2003; Janiga & Costenbader, 2002; Mellard, 2005; Skinner & Lindstrom, 2003) or college to work (Koller, 1994; Madaus et al., 2008b).

High school to college transition.

Janiga and Costenbader (2002) conducted a mail survey of college service coordinators ($N = 74$) to determine their perceptions of students' transition preparedness for college. In this study, participants indicated little satisfaction with transition services, and found students' preparation for self-advocacy a critical oversight of transition programs. This is concerning given it has been well-documented within the LD literature that skills of self-advocacy are necessary if students are to function independently and take responsibility for their learning needs upon entry to college (Durlak et al., 1994; Field et al., 2003; Janiga & Costenbader, 2002; Madaus et al., 2008a; Skinner & Lindstrom, 2003). Based on the findings of their study, Janiga and Costenbader (2002) recommended that high school transition teams provide students with better understanding of their strengths and limitations and of the specific accommodations they may need (Janiga & Costenbader, 2002).

Similarly, Skinner and Lindstrom (2003) identified self-advocacy as a necessary skill for students with LD as they enter college. They also proposed additional strategies thought to promote successful high school to college transition for persons with LD. These included teaching students about their LD and compensatory strategies; teaching students about disability law, helping students select post-secondary programs wisely, working with students and their parents to develop a college entry timeline, encouraging students to self-disclose their LD upon college entry and to seek assistance as needed during their programs, teaching students how to organize for learning and living, facilitating a support network, assisting students in completion of a psycho educational evaluation in high school, and encouraging participation in college preparation programs (Skinner & Lindstrom, 2003).

Durlak and Rose (1994) further suggested these types of transition services and/or gaps are best remedied through the collaboration of both high school and postsecondary service providers. Unfortunately, minimal information exists on such collaborative efforts and/or their effectiveness. Rojewski (in Gerber, 2009), is the only researcher who systematically studied and evaluated high school transition programs. In 1972, through an examination of programs ($N = 9$), he identified seven exemplary components of transition programs critical in promoting students' post-school success. These included individual planning and coordination of services, vocational preparation, academic remediation and support, accessible support systems and services, job seeking and placement assistance, and individual follow-up and follow-along evaluation (Rojewski in Gerber, 2009).

College to work transition.

Students entering the workforce after college also require self-advocacy skills. Madaus et al. (2008a) via a review of the literature concluded that persons with LD in the work setting are generally unaware of ADAA protections and available services. Many lack skills of self-determination, and most do not disclose their LD or request accommodations in the work setting. Given these findings, Madaus et al. (2008a) recommended that prior to graduating their college programs, students with LD need support in developing knowledge and skills in these areas. Specifically, the authors emphasized that assessment of ADAA knowledge and addressing gaps within this domain is a critical element that ought to be included in transition planning for students with LD who aspire to enter the workplace (Madaus et al., 2008a).

According to Madaus et al. (2008a),

. . . students must develop the skills of self-determination, self-advocacy, and self-awareness. They should understand their specific strengths and weaknesses, and know what personal strategies and techniques are necessary to compensate for their weakness before entering the workforce. Of equal importance, transition specialists who are preparing them for successful adjustment to adulthood must be well-informed participants in this process. (p. 152)

Koller (1994) described a transition-to-work strategy called situational assessment. It is intended to assure goodness-of-fit for work through specific job/task analyses. Here, a job coach teaches and assesses the performance ability of persons with LD through a situated learning activity. If limitations to performance are noted, a

strategy or job accommodation is developed and observed for effectiveness. This situational assessment allows for the creation of individually designed strategies to test specific daily vocational job tasks found in authentic work settings. Koller (1994) proposed “. . . directly placing the individual in a real job, the opportunity to observe him or her in a real world environment over an extended period of time provides the best measure of future job success” (p. 41). Authentic work experience, job shadowing, career counseling, and job skills workshops are also believed beneficial to the vocational success of persons with LD (Koller, 1994).

Relevant Nursing Research

Given the significance of pre-transition planning for those with LD, a review of the relevant nursing research was conducted on the topic. Research studies related to nursing students and NL RNs with LD and their transition to clinical practice were sought by searching CINAHL, Google Scholar, MEDline, PsychINFO, ERIC, and Scopus databases using key words including “nurses, disabled,” “nursing students, disabled,” “health professionals, disabled,” “new graduate nurses,” “newly-licensed nurses,” “nursing students,” “medical students,” “transition,” “transition to practice,” “clinical practice,” “clinical learning environment,” “learning disorders,” “developmental disorders,” “mental disorders, chronic,” “Asperger’s syndrome,” “ADHD,” “Dyslexia,” and “disability.” Specific data limits were applied, including peer reviewed research, English language, and a date range inclusive of works between 1995-2015. This search produced a total of 16 articles. None of these articles focused on the pre- and/or post-licensure TTP experiences or related preparation

activities of persons with LD pursuing nursing careers. Furthermore, no studies explored the experiences of U.S. nurses with LD in the workplace.

However, seven of the 16 returned articles focused on the experiences of nursing students or NL RNs with LD from the perspective of those living with LD. Of these seven articles, just one study explored the experiences of U.S. nursing students with LD (Kolanko, 2003). Four studies were found specific to nursing students with LD in the United Kingdom (U.K.), though with a common focus on the experience of dyslexia – a specific form of LD (Morris & Turnbull, 2006; Price & Gale, 2006; Ridley, 2011; White, 2007). Just two U.K. studies (Illingworth, 2005; Morris & Turnbull, 2007) considered licensed nurses with dyslexia in the workplace. I will review these seven research studies in the following pages.

Experiences of U.S. nursing students with LD.

Kolanko (2003), using an interpretive collective case study approach sought to understand what it means to be a nursing student with LD. Participants ($N = 7$) in this study reported they worked harder than their peers without LD to keep up with their studies and stay in the program. Those on the edge of dismissal from their programs said that anxiety interfered with their processing abilities in both the classroom and clinical settings and was a major factor contributing to their poor academic standing. Learning how to work with their LD in nursing, and in turn develop and/or use compensatory techniques as appropriate, was another prominent strategy students used to manage during their programs.

The participants in Kolanko's study (2003) were also very self-aware of their capabilities including their preferred learning styles. Several participants reported

they needed more time for reading, test taking, completion of assignments, and preparation for clinical activities. Some students sought and negotiated these needed academic accommodations; while others indicated accommodations were a last resort for them. For many of the students in this study, the key to their success in classroom and clinical settings was working with supportive faculty members. Positive experiences with faculty reduced students' performance anxiety during testing and clinical activities.

In Kolanko's study (2003), students' also indicated preferred teaching-learning strategies. These strategies were variable and dependent on the task performance required of them. For example, visual learners preferred reviewing textbooks, handouts, and written directions, while kinesthetic/tactile learners preferred to test their learning through direct application of their knowledge during skills labs and clinical practice. Auditory learners reported lecture, discussion, oral directions, reading aloud, and a verbal review of tasks prior to practice demonstration as helpful to their learning. Students also commented on their social learning styles. Some preferred to work independently while others found cooperative learning to suit them best.

Kolanko (2003) also uncovered learning structures impeding and/or facilitating participants' learning in their nursing programs. For example, students noted that classes occurring in blocks longer than two hours were problematic. They found it difficult to focus for that length of time; especially in afternoon sessions following lunch. In addition, transitioning between test taking and learning via lecture or otherwise during the same class period was difficult for them. Breaks, at minimum

every 50 minutes, were crucial in promoting ongoing focus and attention in learning for these students. Overall, classroom learning seemed to present more challenges for these students than did the clinical setting. Students indicated that the long hours spent in the clinical setting were less problematic due to the action-oriented nature of the APE.

Experiences of U.K. nursing students with dyslexia.

The International Dyslexia Association (2015) defines dyslexia as:

. . . a specific learning disability that is neurological in origin. It is characterized by difficulties with accurate and/or fluent word recognition and by poor spelling and decoding abilities. These difficulties typically result from a deficit in the phonological component of language that is often unexpected in relation to other cognitive abilities and the provision of effective classroom instruction. Secondary consequences may include problems in reading comprehension and reduced reading experience that can impede the growth of vocabulary and background knowledge. (About Dyslexia, Definition of Dyslexia, Para 1)

Similar to other types of LD diagnoses, the literature reminds that dyslexia is not related to intellectual ability and its impact varies and changes over time (Morris & Turnbull, 2006; Price & Gale, 2006; Ridley, 2011; White, 2007). Thus, learning needs and supportive measures necessarily require adjustments throughout one's life course (Morris & Turnbull, 2006; Price & Gale, 2006; Ridley, 2011; White, 2007).

Using phenomenological inquiry, Ridley (2011) explored the lived experiences of nursing students with dyslexia ($N = 7$) at one U.K. university. All

participants in this study were formally diagnosed with dyslexia while at the university. Findings indicated that diagnostic testing and appropriation of academic accommodations were lengthy processes - taking anywhere from five to 12 months. The experience of testing for LD was characterized as a formality required by the university rather than an expression of concern for the individual student. Receiving a diagnosis of dyslexia resulted in mixed feelings for this group. Some were relieved to know what the problem was and how they could work with it; yet others indicated dismay with being labeled.

Ridley (2011) also found students in this study concerned about the well-being of others, attentive to safety issues relevant to their dyslexia, and attuned to appropriate safeguards (e.g., supervision, double-checks, and/or disclosure to faculty) promoting positive outcomes for those in their care. Disclosure was reported as a confusing process especially within the practice setting. It was unclear to students who had information about their dyslexia and who they should disclose to in the APE. Students had fears and anxiety about disclosure and they reported faculty, peers, and those working in the APE to have mixed attitudes (either positive or negative) about nursing students with dyslexia. With disclosure, students either experienced support from others or different and/or negative treatment.

In this study, Ridley (2011) also found that self-awareness, reflection, and personal development were key aspects of living with dyslexia for this group. Students sought to learn more about dyslexia, their personal strengths and differences, and ways to compensate or manage in terms of their differences. Though self-awareness prompted increased determination among some students, others expressed

self-doubt, confusion, and low self-esteem in relation to their new dyslexic label. Not surprisingly, students who had intact and encouraging support systems (e.g., mentors, personal tutors, and/or peers) expressed higher levels of self-esteem, confidence, and efficacy in their ability to achieve their professional goals.

Clinical experiences of U.K. nursing students with dyslexia.

Morris and Turnbull (2006) conducted a qualitative study to explore the clinical experiences of student nurses with dyslexia ($N = 18$) and its potential influence on their practice. Five primary themes resulted through this work including disclosure, self-managing strategies, the need for more time, emotional aspects of being a dyslexic nursing student, and choice of future work setting. Six of the 18 participants in the study chose not to disclose their dyslexia in the APE, while another six participants reported disclosure only after support needs were raised by the students' themselves or their faculty. And, the last six participants disclosed at the start of their programs. Discrimination or fear of discrimination was a primary factor in students' willingness to disclose, as was the culture of the APE and students' perceived benefits of disclosure in the setting.

Some participants in this study (Morris & Turnbull, 2006) used self-managing strategies including an audio-recorder to assist with memory recall or clarification as needed. Others indicated using avoidance strategies to reduce stress in situations that called for information retrieval. Practicing psychomotor skills in a safe or stress-free environment was helpful to some students in improving hand-eye coordination and manual dexterity. Most participants reflected self-awareness and the potential for unsafe practice. As such, several reported the need to check and re-check information

prior to medication administration. In maintaining safe practice, students reported that nursing activities required more of their time than was required of their non-dyslexic counterparts. Minimizing distractions in the clinical setting was important to these students as well. However, mentor intolerance related to support needs negatively impacted the confidence of these students in the practice setting (Morris & Turnbull, 2006).

Only two of the participants in Morris and Turnbull's study (2006) referred to dyslexia as a disability, however all described their diagnosis using other negative descriptors including "oddball," "devastated," "labeled," and "different." Many of the students expressed the need for acceptance by others, and indicated they did not want to be viewed as different. Diagnosis triggered reflection on self-image and prompted considerations related to continuation toward their professional goals. Upon reflection, the majority of participants anticipated their hyper-vigilant behaviors related to patient safety would continue. They also expected that slower paced environments would allow them the time and space needed to be safe in the practice setting, as well as build confidence in their nursing practice. Most thought that they were not suited for fast-paced settings and believed such conditions would not only highlight their difficulties, but also amplify them (Morris & Turnbull, 2006).

White (2007), using a qualitative case study method, sought to determine the nature of problems students with dyslexia experienced in developing clinical competence. Through this study, she found evidence similar to Morris and Turnbull (2006) that all students had some difficulty in practice as a result of having dyslexia. Specifically in White's study (2007) students reported challenges in dealing with

information (giving and receiving it when reading and writing was involved), performing the role (managing and prioritizing workload, organizing, and remembering details), and administering medications (reading, spelling, pronunciation, or completing calculations). Factors found to contribute to these difficulties were unfamiliarity with medical terms, limited vocabulary, time pressures to complete tasks, distractions in the environment, and low confidence and self-esteem brought about by negative attitudes and behaviors of others (White, 2007).

White (2007) found that the diagnosis of dyslexia negatively impacted students' self-image, feelings of self-worth, and performance in practice. This finding is contrary to Ridley's study (2011) where some students experienced their diagnosis as positively helpful in self-understanding. All students in White's study (2007) made intentional decisions about disclosure of their dyslexia. Disclosure was contemplated and carried out depending upon students' perceptions of themselves, perceived potential negative consequences that disclosure may have (e.g., stigma), and any foreseeable interference it may bring in terms of meeting their professional goals (e.g., discrimination).

White (2007) also identified measures carried out by students or their mentors that were helpful in addressing certain difficulties experienced in practice and related to dyslexia. Measures of support included the use of information technology equipment (laptops and handheld computers); access to a range of school officials, peers, and family for assistance with coursework or personal problems; and relationships with dedicated mentors. White (2007) found that students appreciated mentors who were approachable, patient, friendly, and allowed them to ask questions.

Mentors helped address dyslexia-related issues by challenging their students, providing constructive feedback on their performance, working with them on language-related difficulties, and collaborating with them in planning learning activities. Students managed their dyslexia in the clinical setting via certain practical strategies like using a dictionary or spell-checker; using colored paper, overlays, or tinted glasses; asking others for help or clarification; looking up terms found in the patient's record; using shorthand in note taking; learning and reciting new words; rehearsing hand-off reports; keeping notes; minimizing distractions in the environment; and maintaining vigilance and caution when performing language-based tasks (White, 2007).

Lastly, students in White's study (2007) articulated characteristics of an enabling APE. Basically students felt most comfortable working in clinical placements where there were consistent protocols and structured routines, and a limited number of staff and patients. They appreciated open, friendly, relaxed environments where they were supported by a good working relationship with their clinical mentor. Within an enabling APE, students indicated they were more likely to disclose their dyslexia and feel happy about doing so. Students expressed more comfort in environments where patients were expected to stay longer, charting by exception was the norm, report writing was minimal, and assistive staff was available to help provide care. Continuous clinical placement (e.g., clinical on Monday and Tuesday) was appreciated more so than shorter stints (e.g., 4-hour days vs. 8-hour days) or broken up by holidays or theory-based coursework (e.g., clinical on Tuesday and Friday). Clinical areas more challenging for these students were those with

variable, unpredictable and time-pressured work. Sites where students needed to remember a vast array of activities and prioritize them for patient care interfered with their learning. Also, students noted that specialized placement sites were less desirable for them in terms of learning. Such sites included the operating room, the intensive care unit, or other locations requiring them to work with multiple unfamiliar terms, equipment, and instruments (White, 2007).

Price and Gale (2006) conducted a study to discover the impact of the dyslexic profile on nursing students in the clinical setting. They suggested that for persons with dyslexia, reading performance (speed, comprehension, and accuracy) is a fragile endeavor. This fragility is most significant when reading performance is required in context. Moreover, the investigators asserted that academic accommodations (often implemented to level the language-processing playing field for students with dyslexia in the classroom setting) are not readily transferrable to the practice setting. Their interpretive study included focus group interviews with two sets of students ($N = 30$) – those with dyslexia ($n = 20$) and those without ($n = 10$). Students in both groups shared similar experiences related to difficulty in understanding medical jargon, language, and abbreviations; understanding the organizational structure and rules within each clinical setting; and coping with frequently changing clinical rotations, inconsistencies in mentorship, and professional variances in work processes.

Key themes that emerged only from the cohort of students with dyslexia included literacy deficits; organizational issues; disclosure, confidentiality, self-esteem, and anxiety; safety concerns; self-assessment; compensatory techniques; and

student dysfunction (Price & Gale, 2006). Specific examples related to these themes were very similar to those found by White (2007), Morris and Turnbull (2006), and Ridley (2011). Students reported difficulties related to reading speed, learning drug names and medical terminology, providing hand-off reports, managing and prioritizing their workloads, and understanding and completing required nursing documentation (Price & Gale, 2006). Participants reported that the workflow idiosyncrasies and clinical practice variations of their mentors further contributed to their inability to perform at a functional level within the clinical setting (Price & Gale, 2006).

Price and Gale (2006) found that students were not offered guidance as to whether or not they should disclose their dyslexia in the practice setting. However, of their participants, all but one disclosed disability in each of their clinical placement sites. For some students this allowed them the space to ask questions, seek assistance, and request supervision as needed. For others, the experience of disclosure left them subject to mistrust, discrimination, and pity by others. For these students, self-esteem became an issue at the point of disclosure, as their confidence dropped and anxiety increased (Price & Gale, 2006).

Similar to the other dyslexia-specific studies reviewed thus far, the students in Price and Gale's study (2006) were also hyper-vigilant about safety. The without dyslexia did not mention the word safety at all or in any way indicate it was of concern to them; however, all the students in they dyslexic group had strategies for promoting safety in practice. Many kept notes throughout the day and requested double-checks on their work or understanding related patient care requirements. Self-

awareness was also a repeated theme in this study. The students with dyslexia expressed an extreme sense of self-awareness as they made repeated references to their strengths and weaknesses as well as compensatory practices. Students employed compensatory strategies including the use of colored pens or stickers for purposes of organization and memory aides. Others requested their clinical mentors break up their workload into small bits or manageable chunks. This helped students pace their work and complete all assignments. Pre-reading prior to clinical placement was a strategy essential for some students. Arriving early to their placement sites helped students who needed to make notes prior to starting their work. Consistent with Kolanko's work (2003), students in Price and Gale's study (2006) also demonstrated and reported working much harder than their peers to achieve the same end goals.

Licensed U.K. nurses with dyslexia in the workplace.

Illingworth (2005) conducted a qualitative study to explore the effects of being dyslexic on the working lives of both nurses ($n = 5$) and healthcare assistants (HCAs) ($n = 2$), and to determine what may improve their working lives. Unfortunately, the findings of this study were not separated by role. Thus, it is not possible to determine the nursing voice verses the HCAs voice within the data as presented by the investigator. However, similar to the experiences of nursing students, practicing nurses and HCAs with dyslexia reported mixed feelings related to their diagnosis. Some reported experiences of being stigmatized because of their diagnosis, discriminated against in promotion and advancement opportunities, and as a result having a negative self-image, low self-esteem, and poor confidence. Negative attitudes in the workplace related to dyslexia were a prevalent in the experiences of

the participants in this study. However, despite the quick misjudgments made by others, these participants demonstrated a persistent determination to prove themselves to their workplace colleagues. Participants acknowledged the value of having trusting, supportive, and protective colleagues in the workplace. However, misconceptions and/or the overt lack of awareness by other staff with regard to dyslexia were commonly repeated stories among all the participants in this study (Illingworth, 2005).

Again, the practice difficulties faced by nurses with dyslexia in Illingworth's study (2005) were very similar to those expressed by students in the other studies reviewed. Coping with time pressures, not having enough time, working under pressure, reading medications, and calculating drug dosages were all a part of the experiences of both practicing nurses and HCAs with dyslexia in the workplace. Also similar to nursing students' LD-related self-management measures, nurses and HCAs in the workplace used specific strategies for overcoming obstacles. These included note-taking, seeking double-checks, reading-back information, using a personal form of shorthand, repeating aloud new names or words, and becoming familiar with clinical documentation records.

Illingworth's study (2005) also highlighted dyslexia-friendly workplace practices. Captured within five categories, such practices were related to (a) information technology (e.g., provision of computers), (b) professional development (e.g., access to courses, extra study leave, handouts), (c) staff (e.g., helpful peers and supportive managers), (d) structure (e.g., clear signage, simple notices with large

words and pictures, swipe card for security access), and (e) ward systems (e.g., consistent and repetitive workflows).

Finally, Morris and Turnbull (2007) conducted a mixed-methods study to explore the effects of dyslexia on the practice and career progression of U.K. RNs. They collected data via a 12-item questionnaire that asked for bio-demographical information as well as qualitative responses about personal dyslexia-related experiences occurring within the workplace. Of the participants ($N = 116$), only 15 had been in practice less than five years, and interestingly, the majority of respondents ($n = 79$) were not diagnosed with dyslexia until after graduating their nursing programs. More than half of the participants worked in community-based settings ($n = 66$), whereas others worked in hospital settings ($n = 47$), and the remainder worked across both settings ($n = 3$). Though role function was varied, the majority ($n = 113$) worked in positions requiring day-to-day client contact.

Morris and Turnbull's findings (2007) are consistent with other research. Dyslexic-specific difficulties reported by the nurses in this study included record-keeping, the need for more time to complete work, medication administration, verbal and written communication, and memory and recall activities. Patient safety was again a common theme related to the practices of these working RNs. In addition, they used similar strategies to promote safe care as previously mentioned in this review (e.g., double-checking work and minimizing distractions where possible).

Morris and Turnbull (2007) were the first to ask participants to identify the positive influences and strengths their dyslexia offered to the practice setting. Nurses described themselves as "determined," "diligent," "creative," "empathetic,"

“humorous,” and “tolerant” (Morris & Turnbull, 2007). In addition, participants described having the ability to think laterally or more holistically, as well as apply common sense in certain situations as added strengths of their disability (Morris & Turnbull, 2007). However, 13 respondents included in this study were unable to identify any positive aspects of their dyslexia (Morris & Turnbull, 2007). This is not surprising, but rather congruent with findings elsewhere pointing to the rampant stigmatization of those with LD diagnoses.

Most of the nurses in Morris and Turnbull’s study (2007) thought that their dyslexia had inhibited their career progression. They believed lack of ongoing professional development opportunities (e.g., additional training courses, advanced educational degrees, and certification exams) to be a primary hurdle interfering with their advancement. They also reported that pre-registration training and academic preparation was a factor in the likelihood of future career advancement as well (e.g., a 2-year program vs. a 3-year program and resulting degree).

Interestingly, the majority of the nurses ($n = 73$) in this study (Morris & Turnbull, 2007) did not think their dyslexia had an influence on their choice of work setting. It is possible that the later-in-life diagnoses for many were a factor in this result. The majority of nurses in this study had practice experience at the time of diagnosis. However, approximately 25% of participants felt their dyslexia played a role in their job choice and work setting preferences. Some even changed work settings only after they discovered certain environments magnified their difficulties.

For this group of nurses, disclosure in the workplace was a selective process, also influenced by perceived benefits and/or detriments the act would have on them

(Morris & Turnbull, 2007). The vast majority of nurses ($n = 112$) in this study disclosed their dyslexia to at least one party within the work setting. Just four nurses chose not to disclose to anyone at all for reasons including fear of ridicule, job loss, victimization, and perceived lack of understanding within the profession. Nurses who disclosed their dyslexia to their managers or colleagues did so to explain some of their characteristic behaviors (e.g., double-checking routines and/or the need for more time), or to reduce the possibility of ridicule or embarrassment. Forty percent of the nurses in this study did not disclose to their immediate managers for fear of negative consequences.

Support for these nurses in the workplace was variable. Just 16 of the 116 nurses in this study felt supported by their managers (Morris & Turnbull, 2007). Most support offered in the workplace came from peers. Just over 40% of the respondents in this study indicated receiving no support at all in workplace; and 27% of this group reported they experienced negativity from their managers at one time or another during their careers. Generally, support offered from peers or managers was practical (e.g., proofreading, extra time, use of computers), emotional (e.g., acceptance and encouragement), and directive (e.g., educational courses, study days, or referrals) types (Morris & Turnbull, 2007).

Best practices in TTP for persons with LD in nursing.

Given that the topic of TTP for persons with LD pursuing nursing careers has been universally silent within the profession, it is not surprising that limited attention has been paid to creating models or implementing interventions that may promote the educational and vocational success of this group in nursing. In this review, I was able

to identify one innovative theoretical model on supporting successful APE transitions in nursing students with LD.

As the first to develop and describe a model for supporting U.K. nursing students with disabilities (including LD) in the practice setting, Griffiths et al. (2010), articulated a six-phase tripartite approach that considers clinical placement pre-planning and modifications as the student moves through different APEs. The six phases include (1) student disclosure and needs assessment, (2) establishment of support systems and processes in practice that promote open dialogue of practice-based adjustments, (3) mid-placement review and adjustments if needed, (4) development of plans/models of support and a critical information base that may serve similar student situations, (5) end of placement review and evaluation, and (6) revision of support strategies where needed. Involved in this approach are the individual student and three key groups: the practice team (including the clinical educator/preceptor), clinical faculty/clinical placement coordinator, and student access services representative versed in APE conditions.

Though this model has yet to be formally and broadly tested, a collective approach to supporting students with LD in the clinical setting has much promise. This kind of approach may best reveal a full picture of students' strengths, as well as strategies that potentiate learning and continued progress toward role mastery within APEs (Griffiths et al., 2010). A limitation of the model is that it relies on students to disclose their LD and potentially early in their programs of study. This may be a barrier to broad testing and implementation of the model given that the findings presented within this chapter indicate many students are undiagnosed at the inception

of their programs. Moreover, disclosure is a complex process for students and fraught with much fear, anxiety, and stress. Not to mention, relying on disclosure positions students point blank for a myriad of potential perceived and/or actual consequences including stigma, discrimination, humiliation, and other forms of derogatory mistreatment. Finally, laws relevant to education and employment for persons with LD in the U.K. are different than in the U.S. Thus, it is unknown if such a model is transferrable to countries with differing laws and regulations.

Summary of Findings

This review uncovered no existing studies on the pre- and/or post-licensure TTP experiences (or related preparatory practices) of nursing students or newly licensed nurses with LD. However, the task provided some insights relevant to aspects of living with LD and its impact on the experiences of nursing students and licensed nurses in the work setting. The findings from this review are consistent with the existing discourse in the LD literature related to the broader experience of disability. They also corroborate much of the theoretical knowledge on the topic and the ancillary, yet related research findings previously discussed. Importantly, much of the research in this area to date has been borne out of the U.K. Thus, the summary of findings reported herein should be interpreted with caution, as the governing laws, rules, and regulations for general education, nursing education, and nursing practice, as well as, societal perceptions of disability in the U.K. are likely quite different than in the U.S.

Nonetheless, the findings of this review suggest that having LD, or being labeled as such in some form compounds and intensifies one's experiences as a

nursing student and/or NL RN in the clinical setting. No matter type of LD, students reported similarly with regard to feelings of self-doubt and personal negativity, as well as experiences of stigmatization and discrimination related to their LD.

Participants in these studies also had mixed feelings about receipt of their diagnosis. Some were relieved to know what their learning difficulty was and how they could work with it to achieve their goals. Others were distraught, terrified, discouraged, overwhelmed, or dismayed with the diagnosis and/or the label. For several, the diagnosis gave them pause to consider their future within nursing. In some cases, participants sought to persevere and overcome their perceived difficulties, while others became less confident in their ability to do nursing work as a career.

Though all the participants in these studies indicated having a grand sense of self-awareness in terms of their learning styles, social styles, and functional strengths and weaknesses in the clinical setting, a diagnosis of dyslexia seemed to intensify the obligation felt by the nurses (or future nurses) with this label to provide safe care no matter the inconvenience of time or effort for others. Likewise, through self-awareness of LD participants' articulated their knowledge of enabling and disabling environmental conditions or situations. Some participants believed that knowing oneself or disability, and having a sense of environmental fit or misfit, guided their employment decisions.

It also seems that many of the nursing students and nurses who participated in the studies reviewed reflected certain aspects of self-advocacy and self-determination. However, no studies to date have examined these concepts in relation to nursing

students with LD. Thus, it is unclear how participants came about these skills or if they were even aware that they possessed them. In terms of this review, the effectiveness of participants' skills in these areas is also questionable. For example, on the one hand many were self-aware of their strengths and limitations, yet not always did they disclose their learning difficulties nor request academic or workplace adjustments when needed. Thus in some circumstances actions of self-advocacy were deterred by fear of negative reprisal. Furthermore, it is unknown how these participants fared in transitioning from secondary education to their post-secondary nursing programs and from the academic setting to the workplace post-licensure.

Finally, it is evident from this review that diagnosis of LD was a critical turning point for the majority of the participants in these studies. However, since just a few participants were diagnosed prior to nursing school or licensure, it remains unknown how an earlier diagnosis may have (or not) affected their career aspirations or paths. Given the stigma of LD and the reported intolerance of those with LD within the nursing profession, it is plausible that earlier diagnoses of LD may have impacted these participants' career intentions.

Though nursing as a profession has an obligation to protect the public from harm, there is no evidence herein or elsewhere indicating persons with LD pose any greater danger to the public than their non-labeled counterparts. Specifically with regard to nursing students and nurses with dyslexia, this review uncovered this group is exceptionally self-aware of their strengths and limitations within the practice setting, and as such are hyper-vigilant when it comes to protecting the welfare of their clients. Furthermore, students with dyslexia, as compared to their non-labeled peers

who did not mention any concern about client safety, demonstrated a heightened duty to promote safe care and protect their clients from harm no matter the perceived or actual inconvenience their efforts may cause for others.

Humans function within complex systems. As a result, all humans are fallible and prone to make mistakes (Parker & Lawton, 2003). This means even nursing students and nurses without disabilities are positioned to make errors when certain factors align. This is the human condition, and as such all nursing students and nurses ought to recognize this as a constant risk, especially when individual decisions and actions involve the lives of others. Based on this review, it seems that both nursing students and nurses with LD are keenly aware of the potential for errors to occur in the clinical practice setting.

Conclusion

As a result of this literature review, I applied in this dissertation study a narrative life history approach to explore LD and capture its influence (if any) on participants' TTP experiences in nursing. Given reported histories of failure and their impact on persons with LD, I also critically examined through this project specific socio-cultural-political forces within the collective histories of this group that contribute to inequities in their pre- and post-licensure TTP experiences within nursing.

Chapter 3: Approach

Introduction

This chapter includes an overview of the aims of this study, background and description of an interpretive approach and narrative life history, the methodological assumptions relevant to life history, theoretical assumptions implicit in the application of the disability studies model, and the critical lens used in this inquiry. In addition, the following pages elaborate upon information about the design of this study including the sampling plan, data collection, analysis methods, and limitations. The chapter also identifies considerations relevant to the protection of human subjects, specifically the process of informed consent and aspects of participant risk, maintenance of confidentiality, and researcher decision-making. Finally, I conclude the chapter with a statement about my own positionality as it applies to the conduct of this research.

Study Aims

This critical interpretive study employed a narrative life history approach to explore and re-present the storied lives of both nursing students and newly-licensed nurses (NL RNs) who self-reported learning disability (LD), including their experiences of transition to clinical nursing practice both pre- and post-licensure. The aims of this study were to:

1. Describe the situated experiences of individuals with LDs in transition to nursing practice (TTP) pre- and post-licensure.

2. Examine the identities and belief systems embedded in the life histories of individuals with LDs that may contribute to inequities within their pre- and post-licensure TTP experiences in nursing.

Interpretive Approach

The interpretive approach has been informed by a number of different scholars and is commonly used to undergird research in a variety of disciplines, including health research (Denzin, 2001). In terms of its heritage, interpretive philosophy has ties to various approaches (Denzin, 2001). These approaches include interpretive anthropology or sociology, hermeneutics, cultural studies, phenomenology, symbolic interactionism, ethnomethodology, the case study method, and Chicago school of sociology (Denzin, 2001). One could write a book about the variations existing within the interpretive tradition. Despite the nuances of varied interpretive approaches, the most common goal in interpretive research is to locate patterns of action within taken-for-granted structures of everyday life including conversation and interaction (Denzin, 2001). Life history research similarly attempts this goal, but with a focus on epiphanies, or experiences that radically alter and shape identities and the meanings individuals give to their life projects (Denzin, 2001).

Life History Method - Description

The biographical or narrative life history method has been a part of sociology's history since the 1920s (Denzin, 1989). It was born of the influence of several sociologists who studied at the University of Chicago at that time (Denzin, 1989). Scholars in succeeding generations turned away from the method favoring problems relevant to measurement, validity, reliability, and theory development

(Denzin, 1989). However, in the last decade, sociologists as well as scholars within other disciplines claimed a renewed interest in the method (Denzin, 1989). This method reappeared in the 1980's and has since been used by scholars within the human sciences (Denzin, 1989).

Life history is a narrative form of research involving examination of personal histories, stories, and artifacts that describes critical turning points in peoples' lives (Denzin, 1989). It is an interpretive approach to understanding biographical experience. As such, this method positions the meaning-making processes of people at the core of scientific explanation (Cole & Knowles, 2001). Rather than assuming that pre-determined concepts, theories, or models apply to participants' lives, a life history approach allows space for the natural emergence of possibilities through the collection of the perspectives of those living the experience (Cole & Knowles, 2001).

There is no one best method for examining lives in context, but rather there are a spectrum of approaches to texts that take narrative form (Riessman, 1993). Choice of method reflects an investigator's preferences in the realms of textual analysis, authorial voice, and representation. The works of Denzin (1989), Cole and Knowles (2001), and Riessman (1993) influenced my narrative life history method. Denzin's (1989) and Riessman's (1993) work assisted me in analyzing and interpreting the texts, and the expertise of Cole and Knowles (2001) guided my efforts in the final representation, the creation of an arts-informed, yet data-based, research product.

Methodological Assumptions

Life history inquiry has been used across multiple disciplines including both education (Casey, 1993; Knowles 1994) and nursing (Bramwell, 1984; King, 1989). Regardless of discipline, investigators applying a life-history approach acknowledge that personal narratives are rooted in time, place, and diverse contexts, and are reflective of broader social life and conditions (Cole & Knowles, 2001). In other words, an inherent relationship is assumed to exist between the general and the particular, whereby the general is best understood through examination of the particular (Cole & Knowles, 2001). Relevant to this research, my assumption is that one's disability identity and experience is reflective of larger social, cultural, and political ideologies of ability and/or perceptions of difference (Siebers, 2008). Therefore, the interrelationship of disability and TTP depends upon participants' histories, personal and professional contexts, and whether solutions exist for the successful integration of disability in TTP (Ingstad & Whyte, 2007). As related to this study, I assumed that solutions as perceived, planned, or actualized in the lives of participants would influence whether TTP was experienced as problematic or not (Ingstad & Whyte, 2007).

Narrative research, including life history, seeks to inform via re-presentation, or an interpreted story (Riessman, 1993). As such, investigators applying life history method assume a life can only ever be known via an interpretation of the words that represent it (Denzin, 1989). Epistemologically, the constructively authored, interpretive, storied product of life history inquiry is the means by which reality can be known. Because life histories inherently require interpretation to produce story

(Riessman, 1993), the collaborative interaction of the teller, listener, and reader ultimately informs the meaning of the text (Cole & Knowles, 2001; Riessman, 1993). Moreover, ontologically no singular truth exists, nor a complete representation of a life, only a re-telling (Cole & Knowles, 2001; Riessman, 1993). This means a life can only be known partially, selectively, and imperfectly via an interpreted story (Denzin, 1989; Riessman, 1993).

Investigators applying life history method participate within (versus outside of) the research frame in the creation of meaning (Cole & Knowles, 2001). Interpretive authority of a life history is thus attributable to the investigator-participant relationship, rather than any particular person (Cole & Knowles, 2001). The notion of *researcher as participant* in the research process reflects an assumption of social constructivism. Investigators using a life history approach assume that individuals subjectively construct knowledge about their own realities through their interaction with the social world (Denzin, 1989). The researcher-participant relationship is social interaction (Denzin, 1989), and this interaction is the avenue by which persons—both the investigator and participants individually and collectively—create and make sense of their existing worlds (Cole & Knowles, 2001).

I selected life history method for this research because it allows for the uncovering of history and biography and the relationships that exist between the two within society (Mills in Denzin, 1989). The method also attends specifically to biographical turning points or epiphanies (Denzin, 1989). These are “. . . interactional moments and experiences which leave marks on people’s lives” (p. 70). With regard to this research, I perceived learning disability to be a biographical turning point that

impacts the identity of persons in varying contexts, their decisions, and ultimately their life course. I assumed that for some it may be a form of epiphany distinguished as a "... *major event*, which touches every fabric of a person's life" (Denzin, 1989, p. 71). To thoroughly explore and understand the TTP experiences of individuals with LD, it was therefore essential to uncover how social identities and belief systems, and respective progressive or regressive changes over time, shaped and/or impacted present day lives and stories of TTP.

Theoretical Assumptions of the Disability Studies Model

The disability studies model falls under the larger umbrella term of Critical Theory as it is commonly called within the philosophy of science. Critical Theory originated through the progressive thinking of German Marxist theoreticians Karl Korsch and George Lukacs, yet the science formally emerged in the 1920s and 1930s at the University of Frankfurt's Institute of Social Research (Wells in Polifroni & Welch, 1999). Critical Theory assumes that human science must be considered within the context of greater social problems, structures, and processes (Wells in Polifroni & Welch, 1999). It involves examination and illumination of socio-cultural and political-economic conditions of modern society that influence human activity (Wells in Polifroni & Welch, 1999). The goal in application of Critical Theory is to identify and critique current socio-cultural-political theories or belief systems impacting the human condition for purposes of motivating moral and/or political action (Wells in Polifroni & Welch, 1999).

In this research, I applied the disability studies model (Siebers, 2008) as a lens for wear during data analysis and interpretation. Consistent with Critical Theory, the

disability studies model encourages the naming of identity and empowers subordinate voices of persons with LD to center relevant issues of difference most often positioned at the margin (Collins, 1990; DeReus, Few, & Blume, (2005); Siebers, 2008). It further allows for the critical deconstruction of disability experience within and across specific contexts (Siebers, 2008). As presented in chapter 2, the disability studies model defines disability as having no essential nature (Davis, 2013; Goodley, 2011; Siebers, 2008). Rather LD is lodged within social, cultural, and political ideologies of ability (Siebers, 2008). These dominant beliefs of ability essentially shape identities of disability over time (Siebers, 2008). To uncover seemingly natural social mechanisms, power relations, and primary influences of dominant society, the disability studies model assumes inquiry must be initiated from the standpoint of persons who claim disability as a positive identity (Siebers, 2008). The model holds the assumption that only the ‘self as disabled’ can reveal societal beliefs about ability and difference (Siebers, 2008) and the hidden power of dominant rhetoric (Collins, 1990). From this perspective, the lived experiences of individuals with LD are valid sources of data that can be collected via research, interpreted (DeReus et al., 2005), re-theorized, and re-presented (Siebers, 2008).

In carrying out research using this lens, I repositioned persons with LD as essential members of society with a privileged view (Siebers, 2008) of the profession of nursing and its dominant ideologies of ability. Specifically, during data analysis and interpretation, I used the disability studies model to explore and uncover within participants’ life histories societal ideals of ability, including those that exist within the nursing profession. Upon uncovering dominant beliefs of ability and difference, I

interpreted their impact on the TTP experience of those with LD. Thereafter I deconstructed dominant belief systems and re-theorized them to prompt critical reflection among readers (those in nursing with or without disabilities). My goal in re-theorization is to empower individuals to take moral-political action promoting substantive social, cultural, and political change (Siebers, 2008) for those with LD who have been historically silenced within the profession.

Study Design

Life history is a form of naturalistic inquiry where data is collected by a human instrument (the researcher) inductively over an extended period of time (Denzin, 1989). Naturalistic inquiry requires an emergent research design that offers flexibility in the exploration and discovery of stories. Investigators performing this kind of research assume change is inevitable and intrinsic to human experience (Lincoln & Guba, 1985). This assumption also holds true in research-related fieldwork. As such, the life history method leaves open the possibility of informally collected stories and artifacts, as well as those purposefully prompted by the researcher (Cole & Knowles, 2001).

Sampling plan.

Interpretive research seeks depth over breadth in data collection; therefore, thoroughly exploring the lives of only one or a few participants is appropriate in life-history work (Cole & Knowles, 2001). I used cross-sectional as well as purposeful sampling to identify information-rich cases expected to illuminate comprehensive insights (Patton, 2002) into three specific TTP experiences common in nursing and as anticipated and lived by those with LD. A cross-sectional sampling approach was

most feasible for this research given my interest in exploring a trajectory of transitions that occurs in nursing over an extended period of time. It was not realistic for me to implement a true longitudinal approach given time constraints of the Ph.D. program. To complete a life history account involving just one nursing student with LD across all transitions of interest (pre- and post-licensure) requires an extensive amount of time, approximately four to five years – time not available to me given regulations specific to the completion of my doctoral program. Even though a longitudinal sampling strategy is preferable for life history method, I assumed a cross-sectional approach could be useful as well in uncovering trajectories of TTP experience. To safeguard against possible limitations, however, I built into the study design time for extended interviews and third interviews of each participant to ensure in-depth exploration of participants' lives and the capture of comprehensive data for analysis.

My sample included two groups: (a) nursing students and (b) NL RNs. Although thoroughly exploring the lives of only one or a few participants in life-history work is typical and appropriate (Cole & Knowles, 2001), given the cross-sectional sampling plan, I determined that inclusion of between six and 12 participants in the study would ensure opportunity for data redundancy. I sought for inclusion in this study a minimum of four students in their Bachelor of Science in Nursing (BSN) programs and a minimum of two BSN-prepared NL RNs who self-identified as having one or more LDs. My sampling plan included:

- TTP 1 (first acute care clinical): inclusion of a minimum of two first or second-year baccalaureate nursing students

- TTP 2 (focused preceptorship): inclusion of a minimum of two senior-year baccalaureate nursing students
- TTP 3 (first job as RN): inclusion of a minimum of two baccalaureate-prepared NL RNs. I also allowed for inclusion in this group NL RNs who experienced an initial incomplete transition-to-work post-licensure.

I focused on these three transitions for several reasons. Based upon my experience as a nurse educator, I was aware that students' first acute care clinical (TTP 1) brings with it much anticipation, excitement, and stress. I also knew from experience that many students enter their nursing programs with aspirations of working in a hospital setting (or acute care). Moreover, I assumed that the first placement in an acute care setting was a potential turning point relevant to students' formation as nurses. I also believed the senior-year preceptorship (TTP 2), since it provides students the opportunity to practice real-life nursing in a specific setting (often of their choice) for an extended period of time, was a probable turning point for students in career decision-making. In addition, it is well-documented that post-licensure transition to practice (TTP 3) is an extremely stressful period that prompts many NL RNs to question if nursing is right for them and/or gives them pause to consider if they want to continue working in their new positions or even in the nursing field. (See Chapter 2 for further details about these specific transitions).

I sought to enroll participants who were diverse in their social divisions and life experiences, yet who were similar in their post-secondary educational paths to nursing, and their clinical transition types. I expected a diverse sample to offer the most comprehensive insights (Patton, 2002) about the intersection of disability and

transition to practice in nursing. I anticipated participants in the study to be similar in three specific areas: (a) self-reported of disability impacting learning, (b) educational path/nursing degree, and (c) clinical transition type. By ensuring some homogeneity in sample characteristics, I expected the collective standpoints of participants as relevant to their TTP experiences in nursing to readily emerge via the data despite other variation in their backgrounds.

I intentionally sought to include in the study students and NL RNs who self-reported LD, no matter their definition and whether or not they had other coexisting conditions potentially impacting their learning (e.g., mental health disabilities and/or physical disabilities). Given the application of the disability studies model in this research, I assumed that those who self-reported LD with the addition of coexisting conditions also held a privileged perspective (and perhaps a more comprehensive view) about society's dominant beliefs of ability and difference. Since disability, according to the disability studies model, has no essential nature (Davis, 2013, Goodley, 2011, Siebers, 2008), having any co-existing conditions impacting learning beyond LD was of no consequence to this research. In fact, I assumed the inclusion of participants with or without co-existing conditions might be beneficial in deepening my understanding of disability and TTP experience.

I excluded from this study NL RNs who did not have BSN degrees. I also excluded student nurses in associate degree nursing (ADN) programs. My initial goal in sampling was to target individuals with limited post-secondary educational experience. However, excluding those with prior college or university credits or degrees proved challenging in recruitment. Several individuals interested in

participating had extensive educational histories prior to the start of their nursing programs. Thus, I altered my sampling plan to include both students and NL RNs who before entering their nursing programs had obtained prior college credit or degrees. Of those who qualified for participation in the study, I selected for final inclusion only those who were able to speak and understand English, had access to a phone, were 18 years of age or older, and were able to provide written consent for their participation in the study.

Sampling occurred until data redundancy became apparent, or until no new information emerged from the interview and analysis processes (Patton, 2002). The final sample ($N = 8$) was diverse in terms of their generational cohort, current socio-economic status, sexual orientation, and religious or political affiliations, but not gender, race/ethnicity, or nursing school. This group consisted of only women (primarily of white race), and all were either in attendance or had matriculated Oregon Health & Science University-School of Nursing (OHSU SON). Participants included three student nurses in their sophomore year of program, three student nurses in their senior year of program, and two newly licensed nurses who were in their first RN jobs and practicing for less than one year. More details about the final sample including demographics and participant histories are presented in Chapter 4.

General recruitment strategies.

I planned to first recruit both the student and NL RN groups from within the Portland, OR metro area, then regionally within a 300 mile radius of Portland, OR. If further recruitment efforts were needed, I was prepared to recruit in neighboring states including Washington, Idaho, and California. Finally, if these efforts did not

provide for a sufficient sample, I intended to extend recruitment nationally. I simultaneously recruited for both the student and NL RN groups, and actual recruitment took place from November 2013 through early March 2014.

Study announcements.

I assured all appropriate Institutional Review Board (IRB) and relevant organizational permissions were granted prior to distribution of any and all study announcements. (See Appendix A, Study Protocol and Appendix B, Lay Language Summary). I used both paper-based and electronic postings (e.g., e-mail, websites, and social media) to facilitate recruitment in both nursing schools and hospitals. I advertised this research as well through my own OHSU faculty and student webpages and offered there a link to the study announcement. All study announcements included a short description of the study and its purpose, an invitation to participate, my contact phone number, and email address. The announcement also informed participants they would receive \$10 per completion of each interview as a token of appreciation for their participation. (See Appendix C, Study Announcement – Student Nurses and Appendix D, Study Announcement – NL RNs). I recruited participants on a rolling and continuous basis until, at minimum, all participant slots were filled in relation to the three TTP events identified. Once potential participants came forth I screened them via phone or email conversation to ensure they met designated inclusion criteria.

Student nurse recruitment.

For student nurse recruitment, I targeted students enrolled in nursing schools in the Portland, Oregon metro area. At the time of this study, there were six colleges

and/or universities in the area offering BSN programs. They included Concordia University; Linfield-Good Samaritan College; Oregon Health & Science University; University of Portland; and Walla Walla University. Beyond the metro area, I targeted students enrolled in nursing schools at George Fox University in Newburg, OR and also OHSU's four regional campuses located across the state of Oregon in the cities of LaGrande, Klamath Falls, Ashland, and Monmouth.

My intention was to locate students who were accessing and/or receiving disability-related services as well as those who were not. To locate potential student participants, I used existing professional connections I had with various faculty and nursing program officials in the Portland area to identify the most appropriate means by which to get information to students about the study. Where I did not have contact, I explored school of nursing websites to identify names and contact information for student access personnel and/or nursing program directors. I worked with these contacts at local area nursing schools to disseminate information about the study via their school websites, Facebook pages, and/or student email distribution lists. I provided my study announcement in both paper and electronic forms to faculty and school officials where allowed and in turn they physically hand-posted the paper flyers for me within their schools and/or made the announcement available to students via electronic communications.

My knowledge of the BSN curriculum at OHSU School of Nursing was helpful in recruitment as well. With permission of specific course faculty at OHSU, I posted the announcement myself to all students within designated courses via the school's online learning platform. Because of my dual role as faculty at OHSU, I was

also able to resource available student email distribution lists organized by nursing class (i.e., sophomore, junior, senior). Using these distributions lists, I emailed students who I knew were anticipating or who had just completed TTP 1 or TTP 2. In my faculty role at OHSU, I am often asked to be a guest lecturer on various topics. As such, I used these face-to-face opportunities with students to announce the study as well.

An adequate pool of qualified student participants emerged from within Oregon. Therefore, recruitment beyond the state was not needed. All qualified student participants came forth from three of OHSU's School of Nursing campuses in response to a direct email notice about the study. They received the notice from me by means of an email distribution list of which they were a part. Though I received eight inquiries about participation in the study from students attending other local-area colleges and universities, they did not meet inclusion criteria most often because they did not self-identify as having a learning disability.

Newly licensed RN recruitment.

For NL RN recruitment, I targeted NL RNs employed in hospitals within the Portland-metro area. At the time of this study, there were eight specific hospitals where I intended to target my efforts. These included Adventist Medical Center, Doernbecher Children's Hospital, Legacy Emanuel Medical Center, Legacy Good Samaritan Medical Center, Oregon Health & Science University Hospital (OHSU), Providence Portland Medical Center, Providence St. Vincent Medical Center, and Portland Shriner's Hospital. If the NL RN participant pool from the local area was

insufficient, I was prepared to extend recruitment beyond the Portland-Metro area to include up to 63 other hospitals within Oregon (up to 300 miles away).

To gain access to the NL RN group I used my existing relationship with the educator responsible for new nurse orientation at OHSU hospital to guide me on the best means of getting information about the study to NL RNs in the Portland-metro area. She provided me with an email distribution list for all new nurses who completed orientation at OHSU hospital within the prior year. Subsequently, I emailed the nurses who were on this distribution list my study announcement with contact information. I gave the OHSU educator my study flier for insertion into her new nurse orientation packets. In addition, the OHSU educator also provided me with her contact list of educators doing similar new nurse orientation work at other local area hospitals. Thereafter, I emailed and/or called those educators to request their assistance with identifying the most appropriate means by which to get information to their NL RNs about the study. I received just a handful of responses from these educators with some referring me to their IRB representatives where required and others requesting my study announcement for inclusion in their new nurse orientation sessions.

The NL RN group proved more difficult to recruit than I originally anticipated. Therefore, I tapped persons who had access to OHSU nursing alumni communications including Linked-In pages, Facebook pages, and email distribution lists. I also paid to advertise the study in the Oregon Board of Nursing Sentinel and the California State Board of Nursing's magazine called *The Nursing Voice*. (See Appendix E, Classified Advertisement). These publications are distributed to all

registered nurses within their respective states. I received no inquiries about the study as a result of this advertisement. Despite my extensive recruitment efforts, just two NL RNs responded to my announcement and both qualified for inclusion in the research study. Both of these nurses matriculated their nursing programs at OHSU. However, the campuses from which they graduated differed. Each learned about the study via direct email communication that included the study announcement. These participants received the email notice with the study announcement from informants other than me.

Data collection.

Data collection for this study occurred via one unstructured qualitative interview and subsequently one to two semi-structured interviews with each participant. All participants told their story via a total of three interviews, with the exception of one individual who participated in just two interviews. First and second interviews lasted 105-120 minutes and final interviews lasted 60-75 minutes. The first interview was purposefully unstructured to provide an informal space for me to get to know participants and their lives as they decided to tell them. Second and third interviews were semi-structured to ensure specific focus on participants' current transition experiences. Second interviews with participants occurred approximately three to four months following their initial interviews. Third interviews occurred three to five months following second interviews. Variations in interviewing timing among participants were unavoidable and occurred for different reasons. Most participants were located a distance from my home, thus for me it was most practical and feasible to schedule multiple interviews on the same day when travel was involved. As well,

three student participants had the summer months off, so it did not make sense to complete interviews while they were out of session and/or not immersed in TTP experience.

I assumed that conducting second and/or third interviews at least three months after participants' prior interviews was ideal, because I might get the opportunity to capture a second transitional milestone (either the start or completion of a specific clinical transition). However, given this was the first study of its kind to focus on the TTP experiences of persons with LD pursuing nursing, it was also my assumption that data collected at all time points, no matter the academic, transition, or employment status of participants, would improve current understandings of the experience of TTP for those with LD and provide a direction for further research.

Interviews.

Before first interviews began, I asked participants to read or listen to (depending on their preference) the details of the consent form. (See Appendix F, Consent Summary & Form). Upon completion of a full review of the consent by each participant, I reiterated its key points including: (a) there is minimal risk to participate, (b) participants' identities will be protected throughout the process and in any future publication or presentation of results, (c) at times participants may experience discomfort in talking about their experience, (d) it is acceptable to discontinue the interview at any time or refuse to answer any questions, and (e) participation in the study is voluntary and participants may withdraw from the study at any time without penalty. After agreeing to voluntarily participate in the study, each participant signed two copies of the consent form, returning one to me and

keeping the other for their personal records. Interviews began upon signed consent and participants' completion of a brief demographic survey that included items like age, gender identity, ethnicity, socio-economic status, and school/employment disability disclosure status. (See Appendix G, Demographic Survey).

I conducted all first interviews, regardless of participants' geographical location, in-person at mutually agreed upon sites with specific attention paid to the convenience of participants. The majority of interviews took place in settings including study rooms in public library spaces or hotel meeting rooms. One interview took place in a reserved conference room in an OHSU SON building and another took place outside in a park-like setting. All second and third interviews were conducted in person as well with the exception of one that took place by phone for feasibility reasons given the geographical location of this particular participant. At the conclusion of first interviews, I asked participants how best to schedule their next interviews and/or contact them for follow-up if it was necessary to clarify or verify accuracy of the interview data. In all cases, I initiated subsequent interview scheduling based upon participants' preferred communication routes. Generally interviews were scheduled via phone calls, text messages, or email communications. In addition, I ensured participants understood they could contact me if they had any questions or comments about the study following any of their interviews.

In narrative research, including life history, participants maintain more power in the research process than do investigators, because storytelling is in the control of participants to a large extent, rather than guided by traditional structured tools provided by the investigator (Holloway & Freshwater, 2007). My goal in first

interviews was to establish rapport and trust with individual participants. I did this by shifting to them the power in storytelling, giving them the opportunity to begin, tell, and end their stories however they liked. In addition, for all first interviews, rather than using a strict, structured interview guide, I initially prompted participants' storytelling via a storyboard. The storyboard in this case was a short script outlining nursing students' and/or NL RNs' typical TTP trajectory. At the conclusion of the script, participants were asked to share their life stories, starting their stories anywhere they desired. If participants had difficulty starting their stories, I prompted them with the question, "Tell me about where you were born, where you grew up, your family, and your childhood." I sought to build a relationship with participants by getting to know their lives (Atkinson, 1998). I anticipated participants' stories would offer data about their family heritage, childhood experiences, youth/schooling, work/community interests, religion/spiritual practices, family activities, leisure, partners and children, reasons for pursuing nursing as a career, memories and reflections on life decisions, and more.

All participants, with the exception of one, had no difficulty with story telling during the first interviews. I found initial interaction with one participant, however, somewhat challenging. Her responses to my open-ended questions were very short and thus it was difficult to maintain a flow or rhythm in our initial conversation. In this case, I referred to my semi-structured interview guide (intended for use during second interviews) to further facilitate this participant's recall and storytelling about her life and path to nursing. This guide included several open-ended questions with

additional probing questions. (See Appendix H, Storyboard & Interview Guide – Nursing Students and Appendix I, Storyboard & Interview Guide – NL RNs).

In first interviews I asked participants to tell me about their paths to nursing and how they arrived at their current place in the world. In these interviews I learned from them about their entire transition trajectory within nursing as it occurred prior to the current transition of focus. For example, first interviews with NL RNs were inclusive of their life experiences, including their transition in nursing school; whereas, second interviews focused more on their present pre- or post-licensure TTP experience.

In second interviews, I began by first verifying the participant's life course and the timeline that I had pieced together based upon the initial interview. I then investigated any follow up questions I had from first interviews. Thereafter, I used the original storyboard with participants, narrowing the focus to their specific transition within it. Thus, these interviews were geared toward topics including transition status, expectations, preparation, supportive structures/processes, barriers/facilitators to progression, successes and challenges, personal compensatory strategies, completion experiences, nursing role and self-concept, as well as other areas of interest that arose during the course of the interview or that I found to contradict my interpretation of the initial interview.

Third interviews focused on follow up questions from second interviews, as well as the capture of all activity occurring since the last meeting. Near the end of each third interview, I shared with participants my initial analysis and interpretation of their life history and journey to nursing. This was a form of member checking, or

the verification of my understanding of each life as told. Most often participants resonated with how I had thematically distilled the events of their lives. In other cases, my interpretation prompted additional conversation that lent to clarifications about participants' stories. These conversations fostered an eventual shared understanding between participants and myself about their life histories, including turning points and their patterns of response to life events as well as TTP experience.

During the research process, I examined specific artifacts or “material culture” (Denzin, 1989) that assisted in contextualizing the intersection of LD and the experience of TTP in nursing. Items I explored to contextualize and also corroborate participants' experiences included course syllabi; OHSU SON application procedures; various course-specific learning activities, job postings; and RN job descriptions. I archived all data in electronic files and folders including interview transcripts and items of material culture in a manner that facilitated for me ease of retrieval and rearrangement. To organize incoming data, I prepared electronic folders entitled: *Artifacts*, *Audio Files*, *Audit Trail*, *Codes-Categories-Themes*, *Demographic Information*, *Consents*, *Field Notes*, *Interview Transcripts*, *Memos*, *Participant Files*, and *Miscellaneous*. In most cases I created electronic sub-folders within each of these primary folders for further organization of the data. My system of archiving evolved over time and became more streamlined as I came to know participants via their stories, including the particulars of their lives as well as patterns of experience that I observed across participant cases (Cole & Knowles, 2001).

Recording and transcription.

I digitally-recorded all interviews using two recording devices to ensure data capture. A paid transcriptionist produced a rough transcription of all recorded interviews via a secure electronic format. This rough transcription was a first draft verbatim of all the words, utterances, and main features of the interview conversation expressed by both the participant and myself, including sighs, pauses, laughing, crying, etc. (Riessman, 1993). During transcription and my own practice of re-transcription, all names or other identifying information revealed in the interviews was replaced with pseudonyms or specific coding to protect the confidentiality of participants.

Data Analysis

Data analysis occurred concurrently with data collection so as new ideas arose from the data they were tested in subsequent interviews where relevant (Riessman, 1993). The data analysis process involved the interaction of *description*, *focused analysis*, and *interpretation*. These types of analysis reflect different intentions of reading and working with the text and therefore result in different levels of meaning making (Cole & Knowles, 2001). Data analysis in this study was not performed with the intention of offering an essentialist version of the TTP experiences of persons with LD in nursing, but instead to reveal the collective standpoints present within participants' diverse experiences (Collins, 1990).

Description.

I performed description upon receipt of rough transcripts of each case to get an initial sense of participants' lives and to determine an organizing approach for

deeper analysis and eventual re-presentation of meanings (Cole & Knowles, 2001). In doing descriptive analysis, I read through each transcript and entered first impression phrases in the margins as I uncovered them in the text. During this process of analysis, I also applied the disability studies model which prompted me to consider: (a) how the narrative was organized; (b) why the narrative was told the way it was to me; (c) the encoded meanings that resided in the form of talk; (d) underlying social, cultural, and political propositions and subtexts specific to ability and difference; (e) and taken-for-granted assumptions held by informants, myself, and the nursing profession (Riessman, 1993). Initial analytic induction of narratives, first applying and then comparing and contrasting first impression phrases within and across cases (Riessman, 1993) resulted in the emergence of broad categories, ideas, and concepts providing a direction for focused analysis.

Focused analysis.

There were definitive steps that occurred during focused analysis; however, the process did not evolve in a clean step-by-step manner. Focused analysis involved repeated immersion within the transcripts (Riessman, 1989). The process was iterative and on some days quite convoluted. However, there were clear-cut turning points in this process that I will attempt to articulate herein including data reduction, coding, and thematic analysis.

Data reduction.

Given the vast amount of textual data I collected during 23 lengthy interviews, I made the decision to reduce the data by eliminating my own narrative contributions from the interview exchange prior to performing focused analyses (Riessman, 1993).

This was justifiable, because my interest during analysis was in examining participants' storylines in their ideal representation without the nuances imposed by the researcher-participant interaction like false starts, pauses, abrupt discourse markers, nonlexical expressions, and other features of my own spoken language that obscured participants' actual stories (Riessman, 1993). Though this practice of removing my own narrative contributions seemingly contradicts the constructivist assumptions held within life history, removing my insertions from the storyline was actually consistent with the application of the disability studies model. Moreover, reducing the data in this manner privileged tellers' experiences and the language they used over that of my own in the shaping of stories as told through the interview process (Riessman, 1993). Despite the use of this data reduction method, I believe that all knowledge and meanings uncovered through the research process were co-constructed through the verbal exchange of ideas and propositions that occurred between my self and study participants.

Coding.

Upon removal of my own narrative insertions from all interview transcripts, I first analyzed each text using initial coding. Here, I attempted to describe via descriptive codes the stories held within each overall transcript. The process was intended as a starting point so that I could get an overall sense of the data and clues about where more data was needed relevant to each mini-story. This step was helpful in breaking down the data into discrete parts to examine them and compare them for similarities and differences across cases (Saldana, 2013). It was also helpful to me in

preparing for follow up interviews and fostered ideas and theories that I was able to test across cases via subsequent exchanges with study participants.

Since first interview transcripts focused primarily on life before nursing school and/or licensure and RN practice, I needed a mechanism for making sense of the vastness of this text. Thus, for first interview transcripts only, I used Denzin's (1989) epiphany framework for analysis. This framework describes four types of problematic moments, or epiphanies, that generally arise in the lives of individuals. Such epiphanies are designated as major, cumulative, illuminative (or minor), and relived. Denzin describes a major epiphany as a moment in time that "... touches every part of the fabric of a person's life" (p.71) and one that has both immediate and long-term effects on the individual. A cumulative epiphany represents "... eruptions, or reactions to events that have been going on for a long period of time" (p. 71). Illuminative or minor epiphanies are symbolic of major issues within relationships. And lastly, relived epiphanies are just that – relived in the moment of the retelling of a significant experience. Denzin purports that patterned responses to life events may be observed via an investigation of these four epiphanic moments. Using Denzin's epiphany framework was a necessary early step in analysis, as it later provided me insights into the relationship of participants' historical life events and their present day responses to TTP experience.

Once I achieved a sense of each life as told via initial and descriptive coding of all 23 interview transcripts and epiphany-based coding of first interview transcripts only, I further reduced the data to focus on stories of transition to practice in nursing that I believed would assist me in achieving the specific aims of this research study. I

located these TTP-specific portions of text and placed borders around them in the actual transcript. Thereafter, I analyzed this segmented data using dramaturgical coding (Saldana, 2013). Dramaturgical coding requires approaching the text as a performance or social drama (Saldana, 2013). This type of coding aligns well with narrative life history as it provides clues into the mission, actions, and thought processes of the protagonist. Specifically, I employed Saldana's six categories of character analysis including: conflicts/obstacles; tactics/strategies; attitudes; emotions; and subtexts. After coding of each TTP text, I organized the codes by code type. Stirring these codes around in various configurations, I was able to discern storylines, interactions, actions, and reactions of each protagonist (Saldana, 2013).

Thematic analysis.

After completion of dramaturgical coding, I wrote a first-person account of each participant's journey through TTP. I subsequently coded these first-person accounts and identified categories of experience across cases. This form of analysis focused more on 'what' was said, rather than 'how' it was said or told (Riessman, 2008). Upon completion of this coding process, I developed a set of themes and thematic categories by considering patterns and meanings expressed in the data, labeling, and grouping them broadly (Riessman, 2008).

Interpretation.

Though my own narrative contribution was excluded during the analysis process, I took into account the social location of participants' stories, how meanings may have evolved, issues of power and privilege, representation of voice, and more (Riessman, 1993). In the interpretive phase, I uncovered categories of lived

experience, root metaphors, life-defining themes and truths, and pivotal turning points of participants' lives (Cole & Knowles, 2001) that ultimately shaped their path to nursing, and specifically their TTP experiences within nursing school and in the workplace post-licensure. My interpretation of the data is presented in Chapter 4 and is intended to stimulate a vision (or re-theorization of TTP) and prompt critical reflection and political action that promotes equity and equal opportunity for students and new nurses with LD entering the profession. Through application of the disability studies model in the process of data analysis and interpretation I was able to discover individual, social, cultural, and political belief systems relevant to ability that may be prohibitive of the successful TTP of persons with LD in nursing.

Rigor/Trustworthiness of the Data

In life history work rigor is equivalent to trustworthiness and rests on the rhetoric of the writing as it stands within the current historical moment (Riessman, 1993). Readers affirm narratives when they deem there is value alignment between themselves, the text, and the narrator, not simply by the presentation of a persuasive argument (Fisher, 1989). The taking in of a story as truth, also known as narrative rationality, is a function of readers' assessments of specific components of the text and how well they align with the values held by readers, and/or persuade readers to shift their values in order to realize alignment with the text and narrator (Fisher, 1989)

Fisher (1989) proposes all human communication is a form of rhetoric. He further suggests that narrative rationality, or “. . . the movement of thought that occurs in communicative transactions, . . . relies on ‘good reasons’ – elements that

provide warrants for accepting or adhering to the advice fostered by any form of communication that can be considered rhetorical” (p. 48). Sandelowski (1991) elaborates on these communicative elements as *narrative probability*, *narrative fidelity*, and *aesthetic finality*. She writes,

Narrative truth is distinguished from other kinds of formal science truths by its emphasis on the life-like, intelligible and plausible story. Stories typically reflect a coherence theory of truth in that the narrator strives for narrative probability – a story that makes sense; narrative fidelity – a story consistent with past experiences or other stories; and aesthetic finality – a story with satisfactory closure and representational appeal. (p. 164-165)

Given the propositions presented by Sandelowski (1991) and Fisher (1989), I outlined in the following paragraphs several strategies I used in the research process to promote trustworthiness and coherence of the final text, as well as a stance of ‘good reason’ among the readership of this dissertation.

Narrative probability.

Assessing narrative probability (i.e., coherence) involves examination of the integrity of the story as a whole. Probability, how well a story hangs together, is determined by (a) argumentative or structural coherence, (b) material coherence, and (c) characterological coherence (Fisher, 1989). To achieve narrative probability in terms of argumentative or structural coherence, stories must flow in a way that embedded arguments make sense to the reader. To promote argumentative or structural coherence, I produced an intentional re-interpretation of participants’ lives that reflects both the ideas presented by participants (or their storied characters) and

offers insight into their realities and experiences of TTP (Carlandson et al. in Holloway & Freshwater, 2007). In addition, I regularly requested reviews of my work by my peers in dissertation seminar and by members of my dissertation committee for purposes of assessing both the accuracy and logical presentation of my theoretical assertions and arguments as they developed and evolved throughout the research process.

Comparing and contrasting alternative interpretations and stories told via other discourses is a means of assuring material coherence (Fisher, 1989). I used artifacts, my research team, my peers in dissertation seminar, and naive readers within nursing education for processes of triangulation, or for comparing and contrasting alternative interpretations of stories told.

Lastly, characterological coherence implies that characters are reliable and predictable in their roles as both narrators and actors (Fisher, 1989). When characters act characteristically or as expected, they tend to be more believable and trustworthy (Fisher, 1989). I used final interviews with each participant to confirm my interpretations of their life histories and TTP experiences. I also requested informal reviews of segments of the developing narrative by my peers in dissertation seminar and my dissertation committee members, one of who is a disability scholar, to promote the reliability of storied characters re-presented within the final text.

Narrative fidelity (truthfulness and reliability).

Readers assess the fidelity of a text by examining individual components of stories held within them and whether they represent accurate assertions of the social world (Riessman, 1993). When narratives are representative of life-like, plausible

situations, they prompt the reader with good reason to believe the narrator's arguments and/or act upon them (Fisher, 1989). To promote narrative fidelity, I kept an audit trail, documenting all aspects of the research process, and I shared my process in regular meetings with my dissertation committee. I maintained consistent field notes after each interview and following each review session with my dissertation seminar peers or dissertation committee to ensure congruence between my decisions and findings concluded in the text. In addition, I implemented a regular practice of reflexivity via journal writing and/or audio-recordings to enhance the fidelity of the representation of participants' experiences and held meanings. Through the provision of individual- and cross-case analyses and efforts to include rich, thick, descriptive accounts of participants' experiences in the final text, I also intended to facilitate judgments of pragmatic usefulness on the part of my readership.

Aesthetic finality.

Readers experience aesthetic finality (or the satisfactory or appealing closure of a narrative) when agreement of the form (the text in this case) is in harmony with their imagination and understanding of life's events (Kant & Pluhar, 1987). Aesthetic finality is a feeling triggered by the representational appeal of an object (Kant & Pluhar, 1987). In the case of narrative, it is an embodied sense of alignment with the re-presentation of the text. To promote aesthetic finality, I requested intermittent reviews of my work by lay readers as well as naive readers within the field of nursing education to explore their reactions and aesthetic responses to key arguments embedded in my developing work and final dissertation product. To maximize opportunities for my audience to experience representational appeal, upon formal

request, I plan to make Chapter 4 accessible via alternate forms to diverse audiences, including persons who do not read or those who prefer other modes of communication for their learning purposes. For example, in addition to printing the final text, I intend to audio record it for public consumption using a professional service (e.g. WeProduceAudiobooks.com) and make the audio version available upon formal written or verbal request.

Human Subjects Protections

The OHSU IRB approved this study. I adhered to ethical principles and OHSU IRB procedures throughout the research process. Upon initial contact with participants, I screened them for their fit for the study. I explained the nature of the study to participants and answered any questions they had about study procedures before securing consent for their voluntary participation. I reviewed and obtained informed written consent during first interviews with each participant, as well as in subsequent interactions. During processes of informed consent, I reviewed with participants: (a) the purpose of the study and consent forms, (b) their right to voluntarily withdraw from the study at any time, (c) procedures relevant to the maintenance of confidentiality, and (d) the possibility of emotional disturbance as a result of sharing their stories. I again answered any questions they had about the study before gaining their signatures on the consent form. Participants were given my contact information as well as Dr. Dena Hassouneh's phone number and email address. In the final representation of participants' lives, I used a composite form of storytelling grounded in the genre of creative non-fiction as a means of protecting participants' anonymity and confidentiality, as well as that of the status quo.

Statement of Positionality

One's positionality impacts their view of the world and how they conceptualize the research project and go about data collection, analysis, and interpretation (Cole & Knowles, 2001). I am a woman, a nurse, a clinical assistant professor, a student, a spouse, an aunt, a daughter, a sister, a friend, and an individual who has felt disabled at various times in my own educational and/or career pursuits. Similar to those with LD in this study, I have also experienced the *closet* and the repetitive process of *coming out*. There are many existing closets in the world. They exist because the people in them believe or have experienced that the world is scary and/or because others do not want to know what resides in the closet. As a lesbian, I hid in the closet and/or found myself imprisoned there at times for more than 10 years in my early adult life. I believe there are many similarities between the disability rights and gay rights movements as they have occurred in my lifetime, especially with regard to the issues of stigma, discrimination, access, and equity. Moreover, I believe oppression is oppression, and that the feeling of oppression, no matter the source of it, transcends human experience. Given my positionality in this world, I sought peer-review intermittently throughout data collection and analysis to guard against my own worldview and the personal biases that come with it. However, I know that there are certainly pieces of my own autobiography that are a part of this study and my findings. This is expected in narrative life history inquiry. As such, I make no claims to objectivity in this research project.

Chapter 4: Findings

The collection of stories presented in this chapter was developed from interviews conducted with both nursing students and newly-licensed nurses (NL RNs) who shared with me in-depth their life histories, including their experiences of ability, disability, and transition to practice (TTP) in nursing.

The Interviews

I interviewed all participants three times over a period of seven to 10 months, with the exception of one who dropped out of the study before her third interview. The study began with six students and two NL RNs ($N = 8$). As a result of the longitudinal aspect of this study, three of the original six students became NL RNs before their final interviews. I carried out all interviews from January 2014 to October 2014. All interviews with the exception of two took place in Oregon and in-person. One of the eight participants, a NL RN, resided outside of Oregon. Thus, I conducted the first interview with this participant in-person in her distant home state and completed the second interview with her by phone. We were able to do our final interview in-person in Oregon. All participants attended and/or matriculated nursing programs at Oregon Health & Science University (OHSU) School of Nursing (SON). The participants were representative of three of five OHSU SON campuses.

Upon initial interviews, three students were in their first year of their SON program of study. Three students were in their last year of program, progressing through their senior year preceptorship experiences. And, two participants were NL RNs who had less than one year of nursing experience and were employed in their first RN jobs in acute care. At the time of final interviews, three participants were

starting year two of their SON programs. Two became NL RNs and began their first RN jobs in acute care, while one passed the NCLEX and was just beginning her job search. Of the two participants who began the study as NL RNs, one reduced her working hours of employment in acute care to part-time and picked up additional hours in a resource job she had on the side in a residential care facility. The other, dismissed from her initial RN job in an acute care setting, was finishing up orientation in a new position in community health.

The Researcher as Instrument

Those implementing life history research assume that the investigator's history not only influences the conceptualization of the endeavor, but every aspect of the research through to representation and dissemination of new understandings (Cole & Knowles, 2001). Therefore, because I was the researcher, the instrument of data collection, analysis, and interpretation, it is important to understand the context that led me to this research and the actions I carried out as I engaged in it. Thus, the following is a brief synopsis of how I came about this project and a description of my interactions with study participants.

I entered the nursing Ph.D. program at OHSU in 2009 with an interest in examining 'situated nursing practice' (Mood, 2009). This was a phenomenon that I discovered and articulated via a conceptual model just prior to entering the Ph.D. program and while in my role as a perioperative nurse educator from 2005-2009. In that role, I observed and interacted with both students and NL RNs in the operating room whom, for whatever reasons, could not perform their roles as expected in that environment. I was at a loss as to how to help this group. I was also unable to

pinpoint the source of the problem for these *struggling* individuals. From my perspective, all were motivated, intelligent, and willing to do just about anything to succeed in the setting. Over time I observed several of these students and NL RNs get squeezed out of nursing or particular settings within the profession, because they weren't able to *get it* or perform within prescriptive circumstances and/or programmatic time limits. I saw some new nurses exhaust everything they had for as long as nine months in the operating room, only then to be cast out by management for not meeting performance expectations. Those were disheartening situations for all because of the amount of time and effort involved on the part of the trainees and the trainers as well as the financial investment contributed by the organization.

From 2009-2011, I also held a faculty position at OHSU School of Nursing while concurrently progressing through my beginning doctoral coursework. In this role, I noticed a sizeable population of students with learning disabilities who were receiving academic accommodations. I also saw that many faculty had difficulty with understanding this group and how best to create inclusive classrooms or clinical experiences that might be effective for individuals with learning disabilities. Thus, I narrowed my population of interest for this dissertation to students and NL RNs who self-identified as having learning disabilities and who were involved in clinical transition to practice experiences in nursing.

As I continued through my doctoral studies, I eventually put aside the concept of situated nursing practice and arrived upon the research question: What is the experience of students and newly-licensed nurses with learning disabilities in transition to practice? Initially, I made the assumption, without considering other

factors simultaneously, that if individuals were not situated in their practice, there was something wrong with them requiring a correction on their part. However, as I gained new knowledge in philosophy of science and research approaches and accumulated more observations of students and new nurses who were labeled as *struggling* (some with and without known LDs), I realized that I needed to zoom out with regard to my research question and early hypotheses around situated nursing practice. As such, I decided that I first needed to understand the experience of this group of students and NL RNs from their perspective in transition to practice before I could intervene as an educator in any meaningful way. My goal in understanding such experience was to identify how I could be a better educator and more inclusive of diverse learners in my teaching-learning practice. I believed the best way to get this information was by talking directly with students and NL RNs. Thus, I eventually narrowed my population of interest to focus on those who self-identified with LD.

As I began interviews, I made participants' aware of my status as an OHSU SON undergraduate faculty member and OHSU Ph.D. student, and I assured them I would maintain their confidentiality with regard to storytelling, particularly in cases where other faculty might be named during interviews. I emphasized that all identifiable information would be de-identified in the transcription process to prevent future discovery of participants and others identified in interviews. To further build trust with participants, I offered them brief information about my clinical background as a perioperative nurse educator and described how I became interested in the topic of TTP specific to students and new nurses with learning disabilities. I conveyed to them that my interest in learning about their experiences was to promote the

inclusivity of diverse learners in nursing education and practice by learning what I could do better as an educator myself to support this end. In turn, I explained my intention was to disseminate the findings of this study to other nurse educators for the same purpose.

Because I had been in their shoes to some degree at one point or another with regard to clinical TTP, many participants asked about my career trajectory and transition experiences in nursing. Sometimes they asked if I knew certain people within their school or area hospitals as well. I shared my understandings when asked, providing enough information to satisfy participants' curiosity, but not too much so as to derail the focus from their storytelling. There were occasions I intentionally offered my own experience without a prompt from participants. These were situations where I felt it was my ethical obligation to do so (Guillemin & Gillam, 2004). For example, I shared my experience in transition to my first nursing job to normalize one participant's story when it was obvious to me that she was struggling to make sense of the transition shock and related emotions she was experiencing.

Participants

All participants identified themselves as female and between the ages of 22-47 years old. In addition, all participants were white with the exception of one who identified as mixed race. Participants disclosed their sexual orientation via our interviews, identifying themselves as heterosexual ($n = 6$), lesbian ($n = 1$), and pansexual ($n = 1$). Married or not, all participants indicated they had a supportive significant other present in their lives. Three participants were parenting school-age children and one participant at final interview was pregnant with her first child.

Participants' social-familial histories were complex and varied, yet all contained stories to some degree of trauma, abuse, neglect, and/or the experience of losing a significant friend or family member at some point during their life course. Six participants indicated they were currently of low socio-economic status (SES), while two noted they were currently of middle SES. For the majority, this was no different than the SES they experienced in their pre-adult years. The educational histories of participants varied as well. With the exception of one participant, all had at minimum one post-secondary degree(s) in hand before beginning nursing school. Three of the eight participants had earned two or more college degrees prior to the start of their nursing programs.

Each participant had a professional work history of some kind, and seven of the eight participants had prior patient care experience in the health care field, including formal work experience in roles such as nursing assistant, medical/clinic assistant, massage therapist, and/or lab tech-processor. Two of the eight participants remained employed on a part-time or as-needed basis while concurrently attending nursing school. These participants worked out of necessity to fund costs related to their education and basic living needs, while others used resources like student loans or scholarships to pay for these expenses.

Through the telling of their life histories, participants identified turning points that led them to pursue nursing as a career. One participant was *called* to nursing, stating she always knew from childhood she was going to be a nurse. Two participants became interested in nursing during their youth or young adult years via personal interactions with or observations of healthcare providers in action, including

nurses. Three participants turned their attention to nursing following their involvement in the illness experience of family members or others of importance in their lives. Lastly, two participants, the oldest members of my sample, chose nursing for practical reasons including perceived fit for the role, income potential, job security, and the vast and diverse opportunities they believed to be available within the profession.

I accepted participants into the study who self-identified as having a learning disability (no matter definition or co-occurring conditions). It is important to recall here that learning disability is an umbrella term that carries with it a variety of definitions and implications in terms of educational accommodation and/or protection under applicable laws. The term learning disability has traditionally been referred to as “Specific Learning Disability” (SLDs). These are considered disorders of basic psychological processes involved in understanding or in using language, spoken or written, that may reduce one’s ability to listen, think, speak, read, write, spell or do mathematical calculations (LDA, 2004). SLDs may include perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Importantly, SLD diagnoses cover only a sliver of disability experience in education, as the term excludes attention, motor, and/or mental health disabilities that may also affect one’s learning experience.

The American’s with Disabilities Act - Title III Regulations (2010) offers a more inclusive definition of disability, including learning disability. Under this law, disability means “. . . with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a

record of impairment; or being regarded as having an impairment.” Here, learning is considered a major life activity. The ADA recognizes that mental and psychological disorders, emotional or mental illness, and/or SLDs may impact an individual’s experience of learning (ADA, 2010). Given that my target population for this study involved adults protected by the ADA (2010), I expected the final participant pool to self-identify with a variety of specific learning disabilities as well as attention issues, mental health disabilities, and perhaps physical impairments impacting their experience of learning. As mentioned in Chapter 2, I also anticipated some participants in this study would have co-occurring conditions impacting their learning as well (LDA, 2004).

Six participants in my study had formal diagnoses while two had their own suspicions about disability given personal histories of educational difficulties and/or partial but incomplete disability testing. Of the six participants with formal diagnoses, only three had acquired and used academic accommodations in their pre-nursing educational histories. The most common disability reported was attention deficit and/or hyperactivity disorder ($n = 5$) followed next by reading comprehension disability ($n = 3$). Participants also reported disabilities including dyscalculia/difficulties with math ($n = 2$), synesthesia ($n = 1$), bipolar disorder ($n = 2$), post-traumatic stress disorder ($n = 2$), dyslexia ($n = 2$), obsessive-compulsive disorder ($n = 1$), and generalized anxiety disorder ($n = 1$). All except two participants had known co-occurring disabilities of some kind.

Six of the eight participants learned of their diagnosis in their early to middle adult years, one participant acquired her diagnosis during adolescence, and one

participant received her diagnosis during early childhood. With regard to their educational histories, all participants described prior experiences of “struggling” to keep pace with the majority in reading, writing, comprehension, mathematical problem solving, test taking, attention/focus, and/or expectations specific to sociability. Participants came to know of their disabilities via their own awareness of “struggling” in the academic setting and/or through observations reported to participants’ by others (teachers and/or family members) and then subsequent referral for formal disability testing and diagnosis.

Theoretical Stance

I applied the disability studies model as a lens in analyzing and interpreting interview transcripts. Unlike the medical approach, the disability studies model does not assume persons with disabilities are defective, ought to be avoided or eliminated, or are need of cure. Rather, the field promotes the study of:

“ . . . social meanings, symbols, and stigmas attached to disability identity and asks how they are related to enforced systems of exclusion and oppression, attacking the widespread belief that having an able body and mind determines whether one is a quality human being.” (Siebers, 2011, p. 3)

The theory claims that dominant ideologies of ability can only be brought to light via the position of one who claims disability as a positive identity (Siebers, 2011). The goal in claiming disability as a positive identity is to advance the meaning and usage of ability beyond its current conceptualization, not to simply fit disability into our current construction of ability (Siebers, 2011).

My Story of Disability

In carrying out 23 interviews, most of which were 90-120 minutes in length, only one participant ever asked me if I had a disability. Given the degree of rapport and trust I felt the participants and I had developed over time, I was surprised that others did not ask the question. I wondered if some assumed I had a disability because of my general interest in the topic and their experience. Or, perhaps it was of no consequence to them so long as they perceived me in some regard as a disability advocate. It was at the our end of a final interview that I had with one participant when she asked me, “Um, do you have a dis, a learning disability? Can I ask that?” Here is the story I told:

Yes, you can certainly ask that. Well, I’ve never been formally diagnosed with a learning disability. But, I feel disabled in certain situations and particularly presenting in front of people, I get very bad anxiety. It's gotten better over time and I think with more practice that helps but my brain goes out the window when I'm in front of people. I have to have a script. Or it's like, it's a big, like it's a big fog . . . I would say there's something going on there. But it’s not something I have to do every day, you know. I'm trying to force myself to do those things [more public presentations] because um, it does help to practice and I feel like I get a little more comfortable every time I do it.

So presenting my dissertation defense is a huge anxiety for me, [laughs] but I'll figure it out. I did my proposal defense and that was okay. I practiced it a lot with a friend using a script. I really try to stick to it because a lot of times when I go off my script then it's, well, over [laughs]. At the

proposal defense, there were actually quite a lot more people than I expected, probably 15 or so. Yeah. I mean, and I'm an instructor, too so I have presented to 65 students before which is really scary and nerve wracking. But um, you know, the more familiar I am with my topic, the easier it is for me. Sometimes I'm teaching on topics I've never taught - that's the worst.

I remember my very first presentation I had to do in a class [as a student]. It was for a graduate class I was taking as an elective to apply to my Master's program in nursing. It was an ethics class or something. It was awful and I had no idea what was going to happen to me. I thought I'd go up in front of the class, do my PowerPoint or whatever and [all would be well]. All of a sudden, just my body took over. It started pretty immediately. It was terrible. Maybe, maybe after I said my first couple words, yeah, it was horrifying. I had tears well up in my eyes. I couldn't see my paper. I was sweating. I could tell my whole face was probably purple, because I was so hot and I had no idea. I didn't expect that at all, but I had never done a live presentation before so that was my very first. I've gotten significantly better in being able to deal with that since then [laughs]. That was about 17 years ago. That was bad. That was, I mean I had tears. I couldn't control them. Like there was, it wasn't controllable. There was nothing I could do. I was like I don't even know if I made sense by the end of that but it was terrible. It was really, really awful. That - I will never forget that [laughs].

Since having that experience, today I still have to do a lot of deep breathing. I try to do a lot of mental calming of my self and a little bit of yoga before I go into a presentation. I have to be like in my zone. [“It just hits you out of nowhere like a brick?” the participant asks me]. Yeah, in my presentations, it's, I can feel it when my heart starts to move you know. I just like, I just stop and take a deep breath and then, or take a drink of water or something to interrupt that and then go back. So that seems to help me a little bit but - So – you know, so we all have something. We all have our own strategies.

I had a class, it was actually a teaching class for um, part of my PhD program, I had to take some nursing education classes and one of them was about teaching and so we had to do this teaching project or we had to develop a presentation and basically teach it to our instructors and our classmates. And um, and we were going to be filmed so we could look at it later and see how we could improve our style or whatever. And um, and I watched it [the film] and I was actually surprised at how far I'd come [since that terrible event]. You know, and I remember that presentation, my mouth usually gets like cottonmouth. I always have to have water while I'm presenting. Um, but I didn't have to take a drink at all. My mouth never got cottonmouth and I just, and I think I moved around the room. I went around the room pretty well. You can, sometimes you can surprise yourself, look for your strengths and you know, look for what you're doing well and keep doing that.

The retelling of my story to this participant prompted me to reflect upon other educational hurdles that I faced in my life. On my drive home after this interview, I remembered the *struggle* I had in matriculating high school. It wasn't because I had terrible grades (they were average to good in my opinion), but the school had implemented a new standardized writing test that all students had to pass before they could graduate. I failed the test twice. Fortunately I was not subject to a third test. My parents as well as others with students in the same position protested the testing process and eventually I was allowed to graduate without further testing, angst, or humiliation. I further remembered *struggling* to achieve an adequate Standardized Achievement Test (SAT) score for college application and later one on the Graduate Record Examination (GRE) for admission to graduate school. I also recalled that upon admission to my first undergraduate college program, as a freshman, I was required to take several assessment tests for reading, writing, and mathematics. After taking the tests, I was deemed a slow reader and also in need of writing assistance per my evaluator. Thereafter, I was required to enroll in a remedial speed-reading course and work with a tutor in the college's writing center. Two Bachelor's degrees and one Master's degree later, I decided I wanted to pursue a doctorate degree in education. I was rejected from the program to which I applied. Looking back on these obstacles, it is curious to me that at the time of these events, I didn't think too much of them. I had plenty of interests and strengths in which I felt confident, and I always managed to figure out a backup plan for getting around obstacles if I felt passionate enough about any particular pursuit.

The context in which we live (real or imagined) shapes our individual responses to life's events and informs our self-concept (Ingstad & Whyte, 2007). My confidence in performing certain tasks like writing, public presentation, and testing was definitely shaken by my past experiences. However, my personal worth and esteem was not. When I consider my experiences specific to performance type tasks, I recall that I had two caring parents who advocated for me and had confidence in my capability to become whatever it was I wanted. I had a consistent social network of supporters in my life as well. Along the way, teachers who were creative in their practice took care and interest in me as an individual, noticed my strengths, built upon them, and/or challenged me in developing hidden ones. I came from a middle-class family, had a decent upbringing, multiple mentors, and many other privileges in my life. Despite the educational hurdles that are a part of my history, I always felt of value as a human being, always capable, no matter my ability to perform in a given moment on specific tests and tasks. I have no memories of being told *no*, nor do I recall anyone in my life wanting me to be something other than happy in whatever it was I decided to do. I never felt like not finishing something or failing in any pursuit would be the death of my self-concept or render me worthless as a human being. This story, my story, may have been told differently had I experienced my educational journey via a different frame of reference and/or an attached label. There are alternate stories. Such was the case in this research.

Claiming Disability

Participants in this study defined disability as a normal, natural, and common human difference. As an individual characteristic (not the whole of an individual),

participants' claimed that disability differentiates individual experiences and perspectives. They demonstrated their claim to disability by acknowledging it as part of their life experience. They observed it, learned from it, navigated it, managed it, and normalized it in varied contexts. The goal for these participants in claiming their disability was to disprove the common meaning of disability as determined by others and issued via a societal label bound by stigma. In the context of academia, participants revealed that having a learning disability means to be "misjudged" by others for not "fitting in," having an "alternate view," "interpreting the world differently," or seeing things that exist "outside the box." In academia, struggles and failures are observable experiences. Per the participants in this study, these experiences were manifestations of being misunderstood. As a result of such misunderstandings, they described feeling "trapped," "alone," "stuck," "lost," "insecure," "scared," "fearful," and/or "self-conscious" while navigating their learning disabilities in certain settings. For all, their disability prompted self-exploration, discovery, and awareness of personal strengths, weaknesses, and learning preferences. All participants sought to understand the label of disability and its applicability to their experience. They used a practice of comparison to others to assess individual *fit* for any formal label given. Some accepted their label (or a portion of its meaning) as given, while others ascribed their own label to fit their experience.

Participants in this study revealed that when an individual is "not getting it" or is observed to be unable to keep pace with the majority, others assume it is a problem or condition, an "injury," "wound," "issue," "flaw," or "demon," specific to the

individual requiring testing, diagnosing/labeling, containing, and treating. Some participants indicated that when their diagnosis or treatment was misunderstood by others, it was assumed to be false, and they were then held suspect – in other words, they were assumed to use the *problem* as “an excuse” for not meeting certain norms or expectations. Participants highlighted that in our society individuals with disabilities are thought challenged, likely to fail, limited, and in need of help. As such, they are commonly considered outcasts. To keep social order, others find it justifiable to discriminate against or inflict other negative consequences on this group. Participants described these consequences as overt (verbal assaults, jokes, sympathy) or covert in form (denied/limited opportunities, varied treatment and/or interpersonal interactions, simple disregard). Those in this study who had a formal disability diagnosis and label experienced stigma and oppression to varying degrees in navigating the intersection of disability and TTP in nursing education and practice. As well, those without a formal diagnosis or assigned label described observations of bias and discrimination directed toward their peers with known disabilities within this context.

Methods of Analysis & Representation

There is no one best method of narrative analysis (Riessman, 1993). The interviews I conducted resulted in more than 1000 pages of textual data. I used initial descriptive coding to get a general sense of each participant’s life. Then, as described in Chapter 3, I identified the major, cumulative, minor, and illuminative epiphanies of each life (Denzin, 1989). This helped me make connections between participants’ individual life histories, major events, and their general coping strategies or patterns

of response. It provided me insights as to what attracted participants' to pursue nursing as a career and what kept them going in their endeavors. After completing an analysis of each life as told, I reduced the data to include only segments of text specifically focused on clinical TTP experience. I applied dramaturgical coding (Saldana, 2013) to these sections of text to determine each participant's objectives, conflicts, tactics, emotions, and attitudes in navigating their TTP experience. After coding each individual transcript, I wrote a summarizing story from the point of view of every participant. Then, I reviewed each summary and compared and contrasted stories across cases. Through this task, organizing categories and themes became apparent revealing a core narrative.

Life history researchers reject the pursuit of one truth or the representation of objective facts, but rather they assume that “. . . all telling is interpretation regardless of whose voice is heard; all interpretation is a fiction despite reliance on *facts*” (Cole & Knowles, 2001). For this study, I embraced an aesthetic, or arts-informed approach in the retelling of my participants' stories (Cole & Knowles, 2001). This practice bridges “. . . the qualities of scientific inquiry with the artistic and imaginative qualities of the arts” (Cole & Knowles, 2001, p.10). The goal in using an art form, like short story, to describe experience is to evoke in readers a feel for the subjective dilemmas of others and to draw them into an interpretive process (Cole & Knowles, 2001).

The short stories revealed in this chapter are a window into the complex lives and experiences of individuals with learning disabilities, as well as broader social and societal conditions that exist within and outside of the nursing profession (Cole &

Knowles, 2001). Multiple interpretations of this work are inevitable and expected (Riessman, 1993). Readers will examine the stories in this chapter through their own individual lenses, make meaning, and form judgments of this work based upon their reading of the text and how it sits within their reality (Cole & Knowles, 2001). My retelling of participants' stories is not intended to convey any particular meaning of truth. The stories as represented are a reflection of my in-depth exploration of the human experience of disability, my interpretation of specific lives, and my theorization about these lives in relation to certain contextual situations and issues as they exist in nursing and beyond (Cole & Knowles, 2001).

To be clear, I assembled the stories presented in this chapter based on my interpretation of the stories told to me and through the vehicle of creative non-fiction. Gutkind (2012) defines the genre as a “. . . literary craft, the technique fiction writers, playwrights, and poets employ to present nonfiction – factually accurate prose about real people and events – in a compelling, vivid, dramatic manner” (p. 6). He reminds that “creative” doesn't mean an author has license to pretend, exaggerate, or embellish facts, but asserts, “It is possible to be honest and straightforward and brilliant and creative at the same time” (p. 6). As the writer of the stories to follow, I pledge to my readership, “You can't make this stuff up” (Gutkind, 2012, p. 7).

The Battle of Becoming

Following data analysis and interpretation, the core narrative emerged as the *Battle of Becoming*. ‘Becoming’ is a process of change or transition from a lower level of potentiality to a higher level of actuality (Collins English Dictionary, 2015). All participants expressed the same objective – “to become a nurse.” All articulated

they wanted to make a difference in the lives of others as nurses via safe, competent, and effective practice. All participants consistently described their journey in becoming a nurse at one point or another as *a battle, a fight, or a struggle*. The enemy these participants faced in their battle was the ideology of ability (Siebers, 2011) as it exists within the context of TTP in nursing education and practice. Through the battle, all participants reflected courage and resilience in their missions to become.

Courage.

Participants demonstrated courage in TTP via acts of self-advocacy and self-defense, particularly in situations that compromised their learning needs and/or the integrity of their developing practice.

Despite the risk of failure, participants also

“Courage is resistance to fear, mastery of fear - not absence of fear.” - Mark Twain

portrayed courage in consistently testing themselves in new situations. Participants were courageous in admitting their learning struggles and reaching out for help when needed, formal or otherwise. All participants showed courage through acts of self-reflection and self-assessment and the honest identification of their perceived strengths and limitations in learning and practice. Some reflected courage in the act of admitting defeat in certain environments and remaining open to other possibilities. Participants also exuded courage through an intentional seeking of feedback and/or the gathering of recommendations from educators for self-improvement. One participant stated she gained new courage through participation in this study, making the decision to get tested for learning disability and to seek reasonable accommodations after years of struggling academically. Each participant revealed a diversity of struggles, yet all participants demonstrated the courage to meet the

struggle head on, acknowledge it, and figure out a way to manage it or use it to their advantage in their battle to become safe, effective, and competent nurses.

Resilience.

For the participants in this study, becoming a nurse was non-

“The greatest glory in living lies not in never falling, but in rising every time we fall.”
–Nelsen Mandela

negotiable. No matter the barriers or the roadblocks in their paths through TTP, they were determined to achieve their primary objective – “to become a nurse.” Most participants were unable to articulate the primary source of their resilience. Two participants believed their resilience was innate, something in their DNA causing their drive. The remaining six participants revealed a need to prove something to themselves, their family members, or society. In most cases, these participants sought to prove themselves to others who at some point in their lives imposed certain limitations on their potential. Participants often reframed negative life events as positive learning experiences. This was a key strategy that appeared to foster the resilience of this group. Regardless of their motivation to survive nursing, all participants demonstrated unwavering resilience in meeting their objective, despite any detriment to their own health, happiness, and personal well-being.

The Stories

To protect the identities of individual participants, the stories presented in this chapter are composite in form.

All names used in these stories

“Nobody who says, ‘I told you so’ has ever been, or will ever be, a hero.” – Ursula K. Le Guin

are pseudonyms. Readers will observe that I do not call out direct quotes within each story. However, it is important to note that I created all stories by weaving together

large amounts of data synthesized across cases for the purpose of representing the Battle of Becoming across time – from entry to nursing school through first RN job. The 10 stories herein illuminate constructions of ability and disability in varied contexts. They also reflect the courage and resilience of the protagonist at different time points in her journey. In essence, each story reflects the collision of life, ability, and TTP within the landscape of nursing education and/or practice. Though the 10 stories stand apart from one another, they are reflective of a trajectory of TTP experiences, or the hero's journey in the battle across time and in various contexts. The following table shows how the stories are ordered, a summary of each story, and the TTP experiences that each reflects.

Table 1.

Overview of the short stories

Story Title & Summary	Primary TTP Experiences
Fit for duty. Beth navigates the school of nursing admission procedure, one that illuminates her academic weaknesses rather than what she later finds are the practical abilities individuals need to become great nurses.	Entry/exit nursing school
Dropping the bomb. Shelly, a first year nursing student, experienced in outing herself (her disability) to various instructors for almost two decades, encounters the need to do so in nursing school as well. She finds herself locked in the disability closet by nursing instructors who don't want to ask or believe they cannot know about their students' disabilities even if students choose to share this information.	Entry to first acute care clinical experience
Calling up my inner soldier. Suzanne, a first year nursing student, attempts to understand what a recent disability diagnosis means for her in the context of nursing education. Unfamiliar with how to manage her disability at this point, her dream of becoming a nurse is threatened. Suzanne calls up experiences from her past and finds within the will to advocate for herself. Thereafter, she consciously positions her self via certain preparatory strategies to survive future threats and ultimately to win the battle.	Entry/exit first acute care clinical experience
Scoping out the beach. Lisa, a first year nursing student, tries to appease her instructors by performing required timed clinical tasks. Battling the traditions held within nursing curricula and the perceptions of some of her instructors about what it takes to be a nurse, Lisa worries about her fit in nursing. With her strengths and weaknesses in mind, Lisa wonders if/how she will find a suitable environment in which she can excel as a future nurse.	Entry/exit first acute care clinical experience.
Another day, another fight. Liz, a senior year nursing student, encounters the daily collision of life, disability, and nursing school in all its chaos. Liz remains committed to her pursuit to become a nurse, hurdling the limiting expectations cast upon her by others along the way.	Entry/exit senior year of program
Passing under the radar. Cali, a nursing student who attempts to navigate nursing academia and practice, finds the written word is privileged over her preferred means of communication. Cali struggles with acknowledging her disabilities in the social sphere. She perceives others will judge her as flawed or incompetent. Her perceptions have been informed by observing how others act in the company of individuals with disabilities.	Entry/exit senior year of program
Arming myself. Julie, during the first year of nursing school, seeks to prevent a repeat failure experience by intentionally setting herself up for success in the academic setting. Julie does extremely well academically but encounters difficulties in her senior-year practicum experience. This raises concerns for Julie and prompts new worries about transition-to-work.	Entry/exit first year and senior year of program
Snipers & allies. Beth, a newly licensed nurse battles the academic-practice gap, a place where preceptors (snipers or allies) either limit or enhance her progress toward becoming a nurse based on their personal beliefs about what new nurses ought to be capable of at certain points in time.	Entry to practice post-licensure
A ticking time bomb. Meredith, a newly licensed nurse, wrestles with the pressure of the orientation clock and her desire to maintain (a) the commitment she made to the organization, and (b) the integrity of her nursing practice.	Entry to practice post-licensure
Adrift. Josie, a newly licensed nurse who was recently dismissed from her first job, finds her mind adrift. After reliving a battle lost, she rediscovers her purpose and sets her intentions on next steps that will help her meet her goal, eventually.	Entry to practice post-licensure

Fit for duty.

As I walk back from the mailbox to my house, I take a deep breath, cautiously peel open the envelope, reach in for the letter, and unfold it. I read:

It is with regret that I inform you that we are unable to offer you admission to the nursing program at Bridgetown University . . . We hope you will consider applying again next year.

“This can’t be happening to me – a 14th rejection letter!” I scream inside my head. “All I want is to be a nurse – a great nurse.” I meet all the requirements. I even have a 3.6 GPA now, but I’m still not good enough to make the cut. At this moment the negative voices from years past are shooting through my head like a show of fireworks.

“Sarah is stupid, mentally retarded, a failure, a disappointment, with a limited future. Let’s test her for X, Y, and Z to see what’s wrong, how we can fix her. She’s a special kid – doesn’t quite measure up to her sister, does she? Only in the 8th percentile for reading comprehension, she needs remediation. Sarah’s lazy, a slacker, a cheater. She should be on medications and removed from the mainstream, isolated, or put in a special school. Statistics show that only two percent of people with dyslexia go on to get their college degree. Really Sarah, why bother?”

My critics tempt me to believe their sermon. My mind is paralyzed rendering my creative problem-solving skills useless for now. I enter the house, sink into my bed, curl up into a fetal position, and cry it out for a few minutes. For a second I even consider throwing my hands to the sky, bowing my head, and surrendering to dyslexia – taking ownership of a fate prescribed by this label’s inherent stigma.

“Well, the world doesn’t stop because you have dyslexia Sarah. The world keeps going, so you need to figure out what to do,” I remember my parents saying this to me when I was just a mere six years old. My emotions taper, and I force myself to get up and move on with the day and devise yet another Plan B.

As I get myself together I hesitantly glance in the mirror that hangs on my bedroom door. A young woman with a reddened, blotchy face and swollen eyes stares at back me. She then speaks three words that reinvigorate my spirit, “I dare you.” Then, momentarily I flash back to high school Spanish class where my best friend Max and I are sitting in the back of the room. In this class, everyone calls me Margarita Vero and he is Darvay Milan. Here I am extremely bored in this drab room with 20 other students. Since I can’t read well and follow what’s going on in class, I twiddle my thumbs to pass the time. As a result of my growing boredom I’m antsy and I can’t sit still. Darvay sees that I’m in need of something to do.

“Hey Margarita, I dare you to eat that entire box of Altoids,” he says. Darvay knows I never turn down a dare.

“Damn him,” I think to myself. So, I pop the entire container of Altoids in my mouth. My tongue, as the mints adhere to it, feels like a raging fire. The sensation prompts a waterfall of tears to stream from my face and drool to drip from the corners of my mouth. Darvay looks at the state I’m in and immediately cracks up, his face purple, laughing, trying himself to hold back tears of amusement. And, of course, at this very moment, Mrs. Canton, our teacher calls on me to speak. I try to respond to Mrs. Canton, but she is clearly disappointed in what she perceives is a ‘lack of give a shit’ that I have for her class and school in general.

“Margarita, please report to the Principal’s office now. I’ll meet you there after class,” Mrs. Canton sternly demands. I’m a jokester, the funny one, a wild child, and throughout school I am forever getting in trouble for stupid stuff. However, I’m also the prom princess and the homecoming queen, very well liked across teenage cliques and varied social circles. When Mrs. Canton and I meet later, she issues me in-school suspension for my antics. Darvay and I are no longer in the same courses together, and I’m off to yet another ‘special’ class intended to tame me.

Eventually my mind returns to the present.

“No one can tame my calling. I’m not giving up on becoming a nurse,” my rational self says to the worn reflection in the mirror. So, I begin again. For the first time I apply to Yates University School of Nursing despite the angst I have about their process, specifically the proctored admission essay. That requirement, my nemesis, in my mind is a set up for another failure. It is a means for others to no doubt discover my reading-writing disability. Nonetheless, I fear this may be my last chance to get into nursing school. As such, I cast aside the insecurities I’ve got about my writing skills and the probable misjudgments of others.

“Just do it, like who gives a shit?” I silently exclaim.

I go to the required testing center to complete the proctored essay. I am nervous and insecure about others discovering my disability and judging me wholly based upon my writing. As I enter the room, I show my ID to the proctor before getting started. The first question asks, “What drove you to nursing?” I want to write about being called to nursing, always wanting to be a nurse, not because of the pay or anything like that. I want to tell the reviewers of my essay that I was driven to nursing

because I like what nurses do for patients in critical moments. I appreciate the role that a nurse has in life. I also want to explain my 20-year journey to nursing, and acknowledge that it took me a long time to academically position myself to get into a program. I want them to know the barriers that I hurdled to get here. Worried that I'm unable to convey my real story within the required word limit, I write instead about a head-on car wreck that I was in, and how I felt helpless and unable to do anything as my friend died right beside me. I write this, a true story for sure, but it's not what drove me to nursing. After I respond to all the essay questions, I print what I wrote, and read, and re-read my paper looking for trouble spots and misspellings. At one point, I fixate on the word *throat* and rearrange the letters multiple times, finally ordering the letters as t-h-o-a-r-t. I hope for the best, and then turn over my essay to be judged.

Months later here I stand again in front of the dreaded mailbox. Nerves fluttering in the pit of my stomach, I reach for the door of the mailbox and slowly open it. I pull out a single letter from inside and via a brief glance note the return address of Yates University. After taking a deep breath, I unfold the weightless letter between my two hands to reveal the news. As I carefully read it, tears well up in my eyes then drip from my face in a steady stream onto the letter. In shock, I re-read it. The letter begins, "Congratulations on your acceptance to Yates University School of Nursing . . ." I pinch my arm to be certain I'm not dreaming.

"Ouch!" I say aloud, and I think to myself, "FINALLY, I'm on my way."

In nursing school I figure out how to be a good a student, and I develop my own study strategies for success in the classroom. I excel in the clinical arena, and my

instructors corroborate this as well.

“Sarah, your strengths are in interacting with people, connecting with them, and helping them to achieve their goals,” they tell me in every evaluation.

Three years later I’m a nursing school survivor with a 3.5 GPA in the record books. I tell my parents that I’m graduating and ask if they’re coming to the ceremony, anticipating from my mother an acknowledgment of my grand accomplishment.

“Well, of course you’re graduating from nursing school,” she says. “That’s what you do if you want to be a nurse. Why would I come? You’ve graduated once before . . . No, I’m not coming.”

“Go Sarah!” I hear these words as I cross the stage to collect my diploma. It’s the voice of my fiancé. He is my one and only cheerleader on this extraordinary day.

Three months since achieving what I consider the success of a decade – that is, graduating from nursing school, my morning alarm sounds. I rollover, hit the snooze button, and in a half-sleep consider what the day ahead has in store for me. When the alarm beeps for the second time, I sit up at the edge of the bed, shake my legs awake, and begin my morning routine. As I pour my first cup of coffee, I think about the initial question that will be asked of me this afternoon.

“Tell us a little about yourself Sarah and why you’re interested in this nursing position at Ridgley Hospital.” Ecstatic by the prospect of such a question and the opportunity to present my social self, and for once a verbal response, I realize for the first time that I’m at an advantage. I anticipate that in this refreshing situation, I will not be judged by my scholastic limitations, but instead on my potential to become a

good nurse and on my personal dare to be a great nurse. I wonder for a moment,

“What ever happened to Max, aka Darvay Milan?”

Dropping the bomb.

It's the first week of the term and I'm in an acute care course. We have two days of clinical this week. The first we spent in the lab reviewing and practicing the skill of medication administration. Today we're going to the hospital with Barb, our clinical instructor. At some point during our shift today and under her supervision, Barb expects us to administer oral medication to a patient.

Per Barb's instructions, I enter the medical-surgical unit at 0630. Immediately I notice that the place is bustling with activity and varied conversations. As I approach the nurse's station, I observe two nurses whispering in the corner. I feel their evil eyes upon me as I approach the area. I notice them zero in on my student status, clearly evident by the school-issued electric blue scrubs that I'm wearing. As I get closer, they roll their eyes, look at one another, and say in synch under their breath, "Oh god." Very self-conscious of the bulls-eye on my back, I take a short detour away from the desk to observe for other cultural nuances embedded in this unfamiliar environment. I quickly try to figure out how I need to be to deflect the perceptions held by some of the unit staff that because I'm a student, I'm of no use here. I don't belong.

Feeling like an outsider is not an unusual state for me. I briefly flash back to a memory from my childhood. I'm 5 years old standing next to my mom's car. It's a Pacer. I know it's my mom's car because it looks like a purple bubble, and I like bubbles. I hold on tight to the silver handle on the outside of the car door. I stand here crying and shaking, because I got lost again in the mall. I just wanted to look at something for a minute, and then when I turned around my mom and two older sisters

were gone. I couldn't find them anywhere, so that's why I came to the car. It's cold and wet outside and I'm shivering now. An older lady with a full head of white hair walks from across the parking lot toward me. When she gets close, she asks my name and if I'm lost. She looks like my grandma a little.

"Shelly," I say to her as I extend my trust and innocence to this stranger. I nod my head up and down in response to her question about being lost. She offers her hand and I take it, and we walk into the mall together. I recognize this as a familiar routine in my world.

"Will Shelly's mom please come to the toy department," the store intercom blares.

Eventually, I reunite with my mom and sisters. My mom shows up in her usual stressed and panicked state and my older sisters, clearly humiliated, pretend not to know me. We leave the mall and I fear I'll receive the brunt of my mom's negative wrath AGAIN once we're in the car.

"Shelly, what the hell am I going to do with you," and so it goes. "Why can't you be smart and responsible like your sisters?" she carries on. "What's wrong with your head child?"

The next time I think we're going to the mall, I'm getting dressed and ready to go, and then I hear the Pacer's engine start. I look out my bedroom window and see the backs of my sisters' blond heads in the purple bubble as it pulls away. I'm not fast enough today so I'm left behind.

Back then I was scared of everything, embarrassed about doing the wrong thing, making people mad, or not being a part of something. As I stand in this stale

white corridor contemplating my next action, my heart hurts thinking about how fragile I was at that age. Still, that experience and years of similar interactions with my mother made me who I am today. I'm a survivor, and I'll continue to survive. Returning to the moment at hand, I think, "The negativity of this clinical environment doesn't crush me. It's nothing compared to my mom's bipolar storms – the ones that trampled my self-worth throughout my youth."

I re-approach the nurse's station. As I scoot by the whispering nurses to retrieve my assignment for the day, I look in their direction, smile and simultaneously offer them a compliment to counter their insidious attack on my lowly student status.

"Cool shoes," I say. Each of them wearing a different pair of colorful patterned clogs, a specific brand of shoe familiar to me, and one I know I can't afford. After reviewing my assigned patient's chart, I immediately seek out Rachel, my clinical partner to verify my understanding of the patient's story. We exchange notes and confer on our plan of action for the day. Then we proceed down the hall to meet our patient.

Once we respectfully introduce ourselves, our patient Mr. Jones, unlike the unwelcoming staff at the nurse's station, expresses a sigh of relief that we are in fact student nurses. To our surprise, Mr. Jones welcomes our undivided attention and is pleasantly agreeable to all of our questions and poking and prodding that is part of the head-to-toe assessment we have to do before giving medications. Once we conclude our extensive examination of Mr. Jones, we intentionally go in search of Barb so that we may gather and administer the oral medications due now for our patient.

Rachel and I position our selves in front of the automatic medication dispenser (AMD) that is located within earshot of the nurse's station and in a high-traffic hallway. With her eagle eyes shooting right through us, Barb now hovers over our every move. As we ready ourselves to embark on the new task, other students from our flock approach the machine to observe our prospective actions. Though we had a brief orientation to the AMD in lab this week, the task of using this machine in real-life seems otherworldly.

"I'll take the first stab with this if that's cool?" I tell Rachel with confidence. Rachel is somewhat timid in the setting. Unlike me, she doesn't have any prior healthcare experience. Thus, without hesitation, Rachel defers to my suggestion.

I go forth and enter the patient's information into the machine. In a millisecond, the computer returns on the screen an extensive list of medications for my review. As I evaluate the information, taking an extra 30 seconds or so to ensure my own accuracy in review of the data. Barb peers over my shoulder to investigate my actions more closely now.

"You don't belong here," Barb says to me out of the blue. "You have no idea what you're looking at or what it means, and I don't think you really get the importance of this situation. You know, you're responsible for these lives." Horrified by Barb's public outburst, I attempt to remain calm.

"I think you misunderstand me Barb." I point my finger to a data point on the AMD screen. "I'm trying to decipher what I'm reading here as far as the dose and what information I can correlate it with to make sure I'm accurate," I explain.

“Don’t wanna hear it,” Barb says with a stern look and gruff voice. “You just need to understand what you’re doing. You shouldn’t have come in today.” I scan the faces of my peers; their eyes wide, mouths closed and silent in absolute disbelief of Barb’s assault on my innocence. Barb turns and begins to walk away from the scene.

“She doesn’t know what she’s doing. Help her,” Barb projects as if she’s speaking through the intercom in the mall. My classmates and I are stunned. Another student, Jason, kindly positions himself under the black cloud cast upon me.

“What’s going on?” Jason says to me.

“Barb is misunderstanding what’s going on, and she’s not dealing with her own frustrations very well.” I take a deep breath to clear my head. “So this is what we’re going to do,” I suggest to Jason. “This is my issue – I’m not very familiar with this machine and this medication program yet.” He nods with understanding.

“You’ve done this right?” I say to him.

“Yeah,” he says. And I point my finger again to a specific section of the screen “Am I seeing and interpreting this correctly?” I ask him.

“Yes,” Jason responds with certainty.

“Good,” I reply. “We’re done. I understand now. Thanks. I really appreciate your help.”

After completing my day on the unit, I approach Barb and request to speak with her in private. She agrees to my request, but she needs a few minutes to wrap things up. I tell her that I’ll meet her outside when she’s ready. While I await my meeting with Barb, I think about the years and years and years, more than 25 of them,

I've spent educating my instructors about my disability. I'm tired of explaining and I'm frustrated by the bias I uncover each time.

“Shelly, tell me what I can do to help you learn and succeed in meeting your goals,” I wish for just once to be asked this question by a teacher. Then, I realize I'm dreaming.

I see Barb exiting the building and walking toward the bench upon which I sit. Returning to the moment, I feel awkward and nervous about the conversation ahead, every past experience of outing myself comes to the forefront of my mind and a sense of dread overwhelms me. As Barb approaches, I recall the last time I attempted to disclose my disability to a nursing instructor in the prior year.

“Oh, I'm not suppose to know that!” my instructor exclaimed after I told her about it. Feeling floored by her comment, at that time I thought to myself, “How will my instructors ever relate to me if they have no knowledge of my strengths and limitations as a learner?” I continue to ponder this today - having to out myself over and over is odd enough, but it really doesn't work for me when my instructor says, “Oh, that's confidential. You can't tell me that.” When Barb sits down, I start the conversation by immediately dropping the bomb.

“I have difficulty with reading and comprehension, but I have strategies to overcome these issues,” I tell her. The position of Barb's brows alerts me of her skepticism. I'm familiar with this look, but I continue to establish my case with care.

“I'm capable of doing this, but I have to use my method to ensure the accuracy of my work. I'm responsible and I know why this is important,” I assert. Barb nods in tentative agreement. I feel my confidence building, and I go on to

describe to her my prior work-related experiences and the strategies that have helped me in carrying out medication handling and administration.

“In all my past experience with medications, I haven’t made a mistake because I’ve been careful in my work. I do triple-checks,” I explain to Barb.

“Uh-huh,” Barb says and continues to nod. Her brows more relaxed now, I sense she is interested in my intentions and where I am taking her in this conversation. I capitalize on her curiosity.

“You know, this hurry up and get it right mandate is not helpful to me or anybody else,” I tell her. “I need to take the time I need to be safe.” I note Barb lacking for words, so I shift the reigns of our conversation to her.

“Do you want me to be safe in patient care?” I ask thoughtfully. For a brief second, I await Barb’s response with the hope of finding common ground here.

“Yes, of course,” she asserts. A shared value lingers between us now.

“Well, that’s what I’ve go to do then, Barb – take the time necessary to be safe.”

Our conversation continues for a bit with me explaining to Barb more in-depth about my disability. When we eventually part ways, I sense that Barb and I have a shared understanding now – something I never had with my mother while she was alive. Though in all the years Mom trampled my spirit, I think to myself, “I never gave up on me, and I never stopped trying to understand her ways.”

Calling up my inner soldier.

It's the middle of the day on a cold, rainy, grey Saturday in January. I'm home alone. My boyfriend is out running errands. The phone rings:

"Hello," I say.

"May I please speak with Suzanne?" the caller asks.

"This is she," I respond.

"Hi Suzanne. I'm Linda. I'm a nurse, and I'm here taking care of your mom at the VA in Michigan. Do you remember me?" she asks. "I was in the last family care conference we had about your mom a few weeks ago."

"Yes, Linda, I remember." I feel uneasy about what's to come in this conversation now.

"Is everything okay with my mom?" I ask.

"Well, your mom has continued to decline since you last saw her Suzanne, and I think she'll die very soon. I'm very sorry," Linda says in a very calm, yet matter-of-fact voice.

"Oh my god. I'll fly there right now!" I respond with a sense of urgency.

"You don't have enough time to do that," Linda says. "Would you like to talk to your mom on the phone?" she asks. "She's not responsive, but she's still breathing and she might be able to hear you."

"Yes, please."

"Go ahead," Linda says. "I'm putting the phone to her ear now." I try to be strong in the moment, yet my voice cracks as I begin to speak.

“Ma- Mom? It’s me Suzanne,” I say. “I know you’re there. You don’t have to respond, just listen okay?” I can’t hear anything but the machines sluggishly chirping in the background.

“Mom - You’ve always worried too much about me, and with good reason,” I say. “But please don’t worry anymore. I’ll be okay. I really will.” Tears flood my eyes as I pause in hope of some kind of response – a breath, a grunt, something. I don’t hear anything from my mom. I continue a conversation from a prior visit we had together.

“I want to tell you mom that I’ve decided to go to nursing school. Yeah, I’m going to be a nurse. What do you think about that?” I ask, knowing full well she can’t respond.

“I’m going to make an impact on this world. I’m going to be a really good nurse, just like the ones you’ve talked about during our visits. I’m going to make you very proud, Mom.” Despite the anxiety building in my gut about what’s happening on the other end of the line, I try to hold it together in what I know are probably my mom’s final moments on this earth.

“Mom, I know you’ve been in a lot of pain these last few months. I don’t want you to be in pain anymore,” I say with certainty. “You can let go now. I love you Mom. It’s all going to be okay.”

Despite her quirks, I cherished my mother and appreciated the freedom she gave me to explore life and figure out for myself how I wanted to contribute to the world. And finally, in the fourth decade of my life after my rollercoaster slows, I settled on a plan to become a nurse. I’m on a warpath to make this happen now, and

it's the memory of these last words to my mother that serves me when the pursuit of my dream is threatened.

The first threat came this year with the news that I have ADD. I learned this at the start of my nursing program and I'm slowly figuring out what this means for me now, and how to navigate the disability-accommodation process within the school. The second threat came today upon completion of a required clinical skills examination, a simulation-based test.

Following my performance on the clinical exam, the proctor Steve says, "We can't pass you."

"Okay, well, that's disappointing, but I get a second chance, right? What do I do?" I ask.

"If we have an appointment available later today, you can come back and redo the simulation," he informs me. "However, we're not sure if there'll be an opening, so you may have to come back tomorrow." I go back later the same day. I repeat the test, and I fail again.

"This means that you also fail the course," Steve says to me after my second failed attempt to appease the testing team. I'm shaken to the core by this news.

"What's next then? What are my options now?" I ask him.

"I'll report the results of the test to your advisor, and then she'll likely meet with you to discuss options," Steve says. I leave the premises as quickly as possible so as not to have a breakdown in front of him.

On my way home, I reflect on what just happened. I'm in shock because I received a wonderful final evaluation earlier in the week from my clinical instructor.

Like a pinball, thoughts race around in my mind and eventually I land on the question, “How did a 5-minute clinical test just ruin my life?” I consider my actions during the test, what I did well and what I didn’t, and how I might do things differently next time. I think about what I know about educational pedagogy. After all I earned a Master’s in Education degree 5 years ago that I have yet to put it to use. Retrieving past knowledge, I recognize that the testing process was not standardized. I received misinformation about preparation for the test. As well, I didn’t get any orientation to the testing environment, as others students told me they did. I also realize, again after the fact, this clinical test was intended as a standardized exam for all students, and thus it may have been reasonable for me request specific testing accommodations, similar to those I use in the classroom.

The next day, students who are in the same boat as me, offer rumors about the consequences of our failure, and some suggest that my dream is now doomed. I’m jarred around by varied emotions. Then, a few days later, my advisor Patrice calls me at home.

“Suzanne, you CAN continue in the program,” she says. I’m somewhat in disbelief given the multiple stories told to me since failing the test.

“Okay. That’s good news, because I’ve invested everything I have into this,” I inform Patrice. My mind momentarily swims with the realization that all is not lost.

“Yes Suzanne, I get that, and please know that I’m not trying to sway you one way or the other,” Patrice attempts to convince me of her good intentions. “But I’ve observed you to struggle since you started the program. You struggled in both of your required science courses.”

“Yes, I know, but I passed. I know I didn’t get an A in those courses, but I passed per the school’s policy,” I respond in defense of myself.

“Well yes, you did pass,” Patrice admits. “But, next term will be more difficult given the course load,” she warns me. She continues her position using my failed clinical test as evidence supporting her doubts about my ability to hurdle what’s to come next term.

As our conversation continues, I sense Patrice is not interested in hearing how the clinical test played out from my perspective. Though I attempt to explain my experience, she repeatedly shuts me down, and her emotions escalate to the point that I feel as though I’m becoming her victim, the one she seeks to weed out of this program. I remember feeling similarly small years ago in my relationship with my first husband. Patrice continues her frustrated rant and my mind swirls back in time to a day 20 years prior when I was working through massage school and married to Pete – that controlling, cheating, lying, abusive bastard. For years I was too scared to ask him for a divorce or leave him, because I feared what the consequences would be for me. So instead, I tried to avoid him while I worked up the guts to ask for a divorce. I relive this memory while Patrice carries on her one-way conversation.

I get up before Pete does. I go to school. I wait tables during the lunch and dinner shift at the local Applebee’s, and then at 9 PM I go to the gym to meet my girlfriends from massage school. After we finish our respective workouts we sit in the lobby of the gym and talk of superficial things for a while before I head home. It’s 11 PM when I get in the house, and I hope to god that Pete is asleep. Like a mouse in the night, I creep upstairs to the bedroom. I peer around the doorway and I see a large

lump of Pete protruding from the covers. I hear him snoring. Whew, I'm relieved, and I get in the shower before going to bed. This is a routine I've taken up for two years, the final two years of our marriage. I wake up the next morning before Pete does and repeat the day again - only this time when I arrive at home he's waiting for me. The night turns ugly and I'm bruised physically and emotionally by morning.

"Don't even think about leaving this house today," he tells me before he leaves for work. "You'll regret it Bitch!"

For the better part of our marriage I felt alienated, alone, with no friends or family ties. Pete and I married right out of high school, and immediately left behind our families in the Midwest for a fresh start together on the west coast. Despite years of repeated circular fights with Pete, and my self-worth in the toilet, I convinced myself, "Pete is all I have in the world." But on this morning, I *wake up* and realize, "I don't even really have Pete anymore." I am done, and I don't care about the consequences. I leave the house immediately after he pulls away, and I don't turn back, ever again.

My attention returns to my phone call with Patrice when I hear her say again, "Suzanne, you CAN come back next term. With a caveat of course, "But maybe this is a time to reflect – spend some time reflecting on whether or not this is the right path for you – you know, if nursing is the right thing for you." I thank Patrice for her words of wisdom.

"No. If there is one thing I know it's that nursing is where I want to be. Nursing is what I want to do," I assert to Patrice before our conversation ends.

By the time we hang up, I'm shaking and nauseous, and in disbelief of the insults Patrice thrust upon my being. Momentarily, my mind, like a slide projector I can't turn off, casts images of Pete in front of me over and over again. Though temporarily shaken by Patrice's volatility and clear desire to sway me out of the program, I consider, "What's the worst that can happen if I continue in the program? I'll fail out? What's the worst they can do to me? Are they going to scrutinize my every move, look for other ways to oust me, set me up for failure, kill me?" These are the thoughts.

"Suzanne, you're here for a reason," I reassure myself. "You're going through this for a reason. Stand up for yourself. You know how to do that."

Four weeks later toward the end of Christmas break and after a load of nightmares and panic attacks about going back to school, I tell my current boyfriend Ron, my biggest supporter, "I'm ready. I'm ready to go back, and I'm ready to focus."

"Good for you Suzanne," he says. "I know you can do this."

"I'm not going to spend my time anymore trying to understand why things happened like they did last term. Instead, I'm going to focus on what I need to know and do to pass this new term. That's what I need to do now."

"That sounds like a really good plan," Ron replies.

"Yeah, I need to call up my inner soldier and get all my mental weapons in good working order before I go back. I'm focusing on that and a long list of other things that I'm going to do for myself to prepare for the new term." Ron hugs me.

“I love your will,” he says with a gentle smile. “I think I now know why I never win our occasional spats.” We laugh together for a few minutes and then move on with the day.

As Ron heads off to work, I think about my mom, a marine, and a fighter until her last breath. I also think about Pete and the strength it took for me to leave him. And today I similarly choose to be a fighter, not a victim. I think to myself, “My mission is to become a nurse, and I will win this battle. I will survive in the end no matter the threats that come my way along this path.”

Scoping out the beach.

As it's engine roars the bi-plane climbs in altitude and eventually levels off around 1500 feet. We're flying over the northern Oregon coastline. There's a pilot manning the controls, but otherwise it's just my clinical instructor, Ann and me sitting near the open door. I can see whitecaps in the turquoise ocean below as well as a few beachcombers scouting the area for washed up treasures. Ann nudges me.

"Are you ready Lisa?" she asks. I scope out the distance between the plane and the beach.

"Not really," I respond tentatively. "Are you sure this is absolutely necessary?"

"Well, if you want to be a nurse then the answer is yes!" Ann replies. Although I do have many MacGyver-like talents, I fear they will not help me in this situation. Ann nudges me again.

"Go on now let's see if you've got what it takes," she says firmly. I unbuckle my seatbelt and begin a very slow crawl out onto the left wing. I look back at Ann with a brave face before I come to a standing position on the wing. I wrap my arms around the crossbar, close my eyes, and take a moment to feel the fierce wind on my face. My task is to complete a medication calculation for Ann before hitting ground. I move my body to the very edge of the wing and then jump. My throat box immediately releases an awkward high-pitched squeal.

"Lisa, Lisa, are you alright?" my partner Gina says as she gently tries to shake me awake. It's the middle of the night and I re-enter reality in a sweat, my heart racing inside my chest, and pins and needles traveling up and down my spine.

“Yeah, I’m okay,” I answer the question in a hazy fog. “I just had a nightmare, that’s all. You can go back to sleep now Gina. I’ll tell you about it in the morning.”

Over coffee and breakfast, I tell Gina about my nightmare.

“Yeah, I think I had that nightmare because of what happened yesterday in clinical.”

“Oh yeah, and what happened yesterday?” Gina asks curiously.

“It was kind of a bad day for me,” I confess. “I was being assessed on medication administration by my instructor, Ann, and just the anxiety of it all, my difficulty with math, my ADD, my little brain, I couldn’t connect the dots for whatever reason, and I just fell apart. First my hands trembled and my face flushed. Then my bottom lip started to quiver and then the tears poured. I couldn’t see past the tears. I couldn’t . . . I was scattered and I couldn’t remember things. I ran out of there and directly to the bathroom. I was embarrassed.”

“Oh Lisa, I’m so sorry. That sounds really awful,” Gina says with sympathy.

“Tell me what happened after you got yourself together though? What did your instructor say?”

“Ann was really nice, very understanding, gave me a lot of reassurance. I was just really stressed, because I was being observed and I hadn’t handled medications in a while. It was horrible, but Ann said it wasn’t. I told her that med-surg is just not for me. Ann was great though. She said all I need to do is to find the *good* beach. That is, the place that suits me best in nursing. It was good advice, but I wish I had the map and a compass to get there, that’s all.”

“When is your next doctor’s appointment again?” Gina, ever solution-oriented, asks me.

“It’s later this week,” I tell her. “Hey, that reminds me, I’ve got to figure out my medications when I go in for that. I feel like I can’t remember anything, I can’t get my brain focused, and my confidence is in the toilet. I wish my brain worked like everyone else’s. I wonder what that would be like?”

“You have a beautiful brain,” Gina says. “I’m glad you’re seeing the doctor soon though. You’ll figure things out. Hang in there, alright?”

“I’m going to,” I tell her. “But it’s frustrating, because there are so many things I have to do to become a nurse. Things that I definitely don’t want to do in the future – like work in a fast-paced setting or in a role where I’ve got to handle a lot of medications. Some days, like yesterday, are just torture for me, and I feel like giving up might not be such a bad thing.”

“You know you’re not going to do that,” Gina says. This is your dream. You gave up everything to go for it – a solid career in movie set design, good benefits, and a nice paycheck. Yeah . . . you’re not giving up on this now. You’re almost there.”

“You’re right, as usual,” I say with a smile. “I just need to figure out where I fit. I don’t know what all the possibilities are yet. I’ve only seen a sliver of them – assisted living, med-surg, hospice, that’s about it.”

“I have faith you’re going to find your beach. Just keep your eyes open for it Lisa.” Gina says with a wink and a smile as she steps away from the table to continue her morning routine.

In the next year of my nursing program, I'm in a residential rehabilitation facility for my clinical rotation. Here, I observe a wound care nurse in action as she cares for a patient with a stage IV wound. I'm stunned by the sheer size and depth of the crevasse. "I bet my biggest mixing bowl would fit inside there," I think to myself as I watch the nurse work. The wound is on the patient's left hip and extends to her left buttocks. I can see bone at the bottom of the canyon. The tissue inside is for the most part a healthy pink color, though there are variations from pale pink to deep rose throughout. Fascinated and practically drooling with excitement, I stand at attention with abundant curiosity. "How in the world is this nurse going to involve herself here to help this patient?" I wonder. Then, I position myself front and center alongside this obvious expert to get a clear view of the nurse's actions as she combines foam and plastic and tape and other materials to make a cool customized dressing for my patient. As I watch her work meticulously to craft this apparatus, I consider, "I can totally do that. This role encompasses all the things I'm good at. This is where my MacGyver skills fit!"

After some self-study on the role of the wound care nurse, I drop in to visit with my advisor, Maryanna to see what insights she might offer me about wound care nursing – my new found heaven on Earth. Once seated in her office, I tell Maryanna about my clinical observations and what I've learned about the role so far.

"Tell me what interests you specifically about the role Lisa?" Maryanna asks.

"It just reminds me of the skills I already have, you know? This is odd to say, but I have skills from being a working artist from my life before nursing," I explain. "I did lots of theater and digital illustration and costume design. I built props. You

name it, I could make anything out of anything, like complete theatrical sets with whatever scraps were available to me.”

“I never really thought about the role that way before, but it certainly sounds like a good fit based on your skill set,” Maryanna says in agreement with my self-analysis.

“Yeah, I told some of my instructors from last term about this too – that I really want to focus on wound care.”

“And what was their response?” Maryanna asks with curiosity in her voice.

“They hugged me and they said that it’s perfect,” I explain. “They know that I struggle in complex environments and with hardcore medication calculations. I mean I can handle drawing up Marcaine or whatever, but as a wound care nurse I won’t have to be responsible for juggling a ton of other stuff too. You know, the chaos in the hospital setting that’s so stressful me. This is a role I can feel confident in – I think it could be my niche.”

“Well that’s really wonderful to hear Lisa,” Maryanna declares.

“I think it’s great too, the only thing that worries me is that I might have to go toe-to-toe about this with some of the instructors I’ll have next year. I mean, I’m planning to do my very best in all my clinical rotations, but there are just some things that I know I’m not great at.”

“Yes well, that’s true for all of us I suppose?” Maryanna says.

“Yes. And, I don’t think I need to be great at everything to be effective as a nurse. I’ve seen that now.”

“Uh-huh. I think your right Lisa,” Maryanna responds. “There are multiple, diverse roles for nurses out there.”

“Yeah, so I’m going to take whatever time I need to get things right in every setting – simulation, the emergency room, med-surg, wherever I’m placed for clinical in the coming years. I need to do things a certain way and at a certain pace to keep people safe. I know this. It’s just hard sometimes to get my instructors to understand that and where I’m coming from.”

“Well, Lisa, please let me know if there’s anything I can do to help with that,” Maryanna says. “I think you’re on the right track, and I know you take what you’re doing here very seriously.” I thank Maryanna for her support.

“Oh, don’t worry, I’m definitely going to speak up to my instructors or to you if I run into any snags. That’s for sure.”

I leave Maryanna’s office and meander down the hall toward the building exit. I feel content now, realizing I’m no longer lost in a game of clue. “I’ve found my beach, and I’ve got just the right amount of stamina left in me to swim to it. It’s a good beach. I’m going to survive on that beach,” I proudly think to myself.

Another day, another fight

I enter the School of Nursing at 8:55 AM and head for my 9:00 AM leadership class which is scheduled to go until 1 PM. “I probably should’ve taken my medication this morning,” I think as I hurry to the classroom. But then again, “I’m almost out. I have no refills left. I don’t get paid for another week, and I need to conserve what I have left to survive the mid-term exam next week.”

I enter the classroom and look for a seat in the back of the room, but I see they’re all already taken. Instead, I spot an open seat in the middle of the room. “At least it’s by the wall,” I think to myself. “It’s okay, challenge your self today Liz,” I say in my head.

Once seated, per my routine, I visualize a possible attack of some kind, I scan the room identifying the location of the doors and windows and plot an evacuation plan, including a strategy for saving my self as well as my fellow classmates. I consider all that could go wrong with my plan and a variety of alternative actions I can take should my worst nightmare come true. With a firm exit plan intact, I attempt to access my *zone* to manually reduce my elevated heart rate and blood pressure before class starts.

At 9 AM sharp Allen, the professor, begins his PowerPoint lecture, my mind drifts, and I wonder, “Did I put money in the parking meter before class? I definitely can’t afford an expensive ticket.” Already a blur, I trace my steps and think back on my morning – I remember waking up at 5 AM in a fog after a long night of studying, drinking a pot of coffee, scarfing down a banana for breakfast, calling to schedule an appointment with my doctor, deciding intentionally to skip my medication routine,

packing a bag for Brian (my son), getting Brian dressed and ready for his day, and then dropping him off at his grandparent's house. This, all of it, I managed before I got to campus today. I think to myself, "I was too impatient with Brian this morning. I'll need to make it up to him later." Then I consider, "What else? What else happened this morning?" I remember arriving at school, where I parked, and finally, my memory serves me, "Yes, I did put money in the parking meter! Whew." I exhale a sigh of relief.

Returning my attention to Allen, his lecture concludes.

"Okay, let's get into small groups now, 5-6 students per group," he instructs. "Then, I want you to discuss in your groups what it means to be a leader based on your clinical experiences to date and the article assigned as pre-reading for today." Allen writes three questions on the white board for students to ponder in their small groups. I begin to feel very dumb. That damn thing is happening again. I read the first question on the board, but I don't understand what the hell it is asking. I take it one word at a time, but it doesn't help. I secure the first word in my head and I know what it means, then I move to the next word, and then the first word disappears from my mind.

"Shit!" I silently scream in frustration. "I wish I could focus. I wish I didn't need medications to focus. I really want to do this on my own! I have high goals and I should be able to do this." Some of the students in my group begin to converse with one another, and I feel light years behind them in the moment. Upon this realization, I make an effort to get caught up with everyone.

“Yeh, I’m so mad. I forgot my damn glasses today,” I lie to my classmate, Arlene, who sits next to me. “Can you clue me in on the question we’ve been asked to discuss,” I ask her.

“Sure,” Arlene kindly responds. “We’re supposed to talk about someone we know who is a leader in our eyes and why we believe that individual is a leader.” I thank her for bringing me up to speed. Then, I join in the small group discussion.

As hour #4 of class gets underway, there’s a guest speaker now from the State Board of Nursing presenting a PowerPoint lecture on the topic of delegation. “Oh god,” I think to myself. “I can’t sit through another lecture.” Feeling extremely uncomfortable and anxious, I tap my fingers on the table and move my head slightly back and forth to a tune in my head. I hum quietly under my breath.

“I can’t sit by you in our next class. I can’t do this,” Nancy, my good friend, says to me in a whisper as she leans in from behind me. “Will you please try to be still? You’re making me crazy,” she further asks with a smile.

“Sorry,” I whisper to her. To appease her request, I find an alternate activity to center my focus. I doodle and draw on the handout in front of me. After creating a few sketches, I make a list of groceries I need to get from the store later on my drive home, and then jot down a list of all the assignments I know are coming due in the next two weeks. As well, I intermittently observe for any threat of attack on the class, and reconfirm my exit path, just in case I need it. After an hour or so, I re-focus my attention on the lecturer.

With 45 minutes left of class time, I notice the clock on the wall and realize I need to put more money in the meter now. However, I hesitate to leave class at this

point knowing I will interrupt Allen's final lecture and disrupt the learning of my peers. Also, Allen, I know at the end of class, expects us to grade ourselves on our individual participation, as well as justify our grades with evidence. In my mind, I debate what to do. "If I leave at this point (and even if I come back), I know I can't give myself full credit, and I really want to get an A in this class." I take my chances and silently pray to the parking gods that they'll have mercy on me today.

The time is 1 PM on the dot, class is officially over now, and my mission is to get to my car as quickly as possible. I attempt to avoid all eye contact with others as I hurriedly walk to the front of the classroom to turn in the participation grade I assigned myself. Freedom is near as I approach the door's threshold.

"Liz, can I speak with you for a moment," Allen calls out to me just as I'm about to leave the room. The classroom empties completely and it's just the two of us. "Liz, I noticed that you were very fidgety in class today, and the questions you asked were a bit out of synch with where we were in lecture. I just wanted to check-in to see what was going with you, and to learn if there is something I can do to help or support you during future classes."

"I'm just a little under the weather today. That's all," I explain. I feel awful and embarrassed that I caused Allen such concern.

"Okay then," he replies. "I just wanted to make sure there wasn't anything else. If you're not feeling well, perhaps a visit to the Student Health Center might be a good idea?"

“I’m managing for now,” I reassure him. “But I’ll keep that resource in mind.” Heading for the door, I pause my stride for moment, turnabout, and I say with a half smile, “Have a good day Allen, I’ll see you next week.”

As I head for the exit doors of the school, I see buckets of rain are pouring down from a very grey sky. I pull the hood of my rain jacket over my head and quickly gallop toward my car. As I approach I see a bright yellow envelope under my driver’s side wiper blade. “Oh god not another ticket!” I yell inside my head.

Trying to get out of the rain, I carelessly tug on the soaking envelope to remove it from the windshield. As I do this, half of it pulls away, while the other half remains stuck under the wiper blade. After collecting the rest of the ticket, I drive away, frustrated and overwhelmed; a knot of raw emotion builds in my throat. I take a deep breath, turn up the radio, and mutter aloud, “Another day, another fight. I’ll deal with this ticket later.”

Two weeks thereafter, I’m walking across campus to my 9 AM leadership class from an 8 AM counseling session I just had at the Student Health Center. I enter the classroom quietly with my head down. I know my face is a mess from the cry I just had in therapy. Once I settle in my seat, I assume all eyes are upon me. I hesitantly look up toward the front of the classroom in an attempt to orient myself to the content at hand. There’s a guest speaker at the front of the room and Allen sits in a chair off to the side. My eyes meet Allen’s and I sense given my disheveled state that he continues to be concerned about my well being, especially considering how poorly I performed on his mid-term exam last week, and now my tardiness to class this morning.

Despite my efforts to look busy, Allen approaches me at the first break.

“Liz, can we chat briefly in my office,” he asks. I agree and we walk down the hallway to his office. There’s a small table in the room with three chairs that surround it. Out of habit, I intentionally plop myself in the chair nearest the door in case there’s an imminent attack of some kind and I need to exit expeditiously. Despite my experiences of sexual abuse in the past, I feel comfortable with Allen. He was my clinical instructor for two classes I had earlier in the program as well. I have never seen Allen to be anything other than kind or caring toward his students. He closes the door quietly and sits across the table from me.

“Liz. I’m very worried about you,” he leans in with a serious look of concern. “You’ve been engaged in this course since the start, but I’ve noticed some recent changes in your performance. Is everything okay?” I feel a little flustered by Allen’s question, and I pause to consider how I’m failing in so many aspects of my life right now.

“I just came from a therapy session with my counselor,” I tell Allen, giving in to his inquiry. “I have PTSD and probably ADHD, and things have been very hard lately. I have a lot of anxiety about school and I can’t focus very well right now.”

“Do you have medications that help with that?” Allen probes.

“Yes. I take an anti-anxiety medication, and I keep extra on hand in my purse at all times just in case. I have a medication that helps me focus too, but I need to first see my doctor before I can get a refill. I have an appointment later this afternoon to do that.”

“Good,” Allen says. “Well, we just need to get you through this academic stuff so that you can get to the clinical setting where I know you excel. You just need to pass your classes so you can move on.”

“I know. I’m just so afraid to fail,” I confess. I wonder every day if this is it. Is this the day I’ll be kicked out of nursing school? What would I do then? I mean, this is what I’ve set my mind on doing, and it’s taken me a long time to get here.”

“Liz, you’re a good student in my book,” Allen says. “No one will know if you pass your nursing courses with an A, B, or C. Most employers don’t ask for your grades. And, grades I know are not an indication of one’s performance as a nurse.” Feeling the support of Allen, I nod to indicate my understanding of his wisdom. “I know plenty of nurses who struggled – struggled the entire time through nursing school,” Allen continues. “Getting C’s was the best they could do. But, they are wonderful nurses today. So keep that in mind, Liz. All you have to do is pass. Try not to beat yourself up and stress about getting high marks on everything.”

“That’s easier said than done,” I think to myself. My mind flashes to an encounter I had with my mother last week, her words, the degradation, and constant comparison of me to my brother, the superior being in my mother’s eyes. Seconds later I return my focus to Allen’s face.

“Thank you for the encouragement Allen. I’ll try to give my self a break once in while,” I say aloud cautiously. As our conversation dwindles, I stand up feeling somewhat relieved by Allen’s support and I tell him, “I better get back to class now.”

Five months later I hear my name called followed by the words, Summa Cum Laude. I am truly amazed in this moment as I walk across the stage to gather my

diploma. After all names are called and the ceremony concludes, I search for my parents in the crowd that swarms outside the auditorium. Fortunately, the momentum of the scrum leads me right to them. As I approach, they are both smiling from ear to ear and extend their arms to me for hugs and kisses.

“I’m so proud of you,” my dad says to me. “I can’t believe you graduated Summa Cum Laude. That’s amazing!”

“Yep, I did it!” I reply with excitement.

“I didn’t even think you could do that. I had no idea you were that smart,” he continues. Bewildered by my father’s comment, a sole proud moment slips from my grasp, and I am now small again.

Passing under the radar

I'm seated in a café waiting for my best friend Hannah to meet me here. While I wait, I stare off out the window and think about the first time Hannah and I played together in her backyard. I'm seven years old and she is the same. As we run around playing together, I feel free – out of the reach of my mother and teachers. These are the people who pin me in a corner and try to force me to read everyday. I can't read. I hate reading. It's hard for me.

But Hannah, everything about her is animated. As we work together in her yard on our fort, I observe her every move, the contortions of her face, her busy arms and hands, and the air she moves intentionally through either pursed or open lips. I make it my goal to understand her. Though I'm very young, I'm aware that she's so much more interesting to me than words on a page.

My attention returns to the moment when I see Hannah walking toward the door of the café. She enters with an air of confidence about her. I wonder, "Will I have that? Will my mind ever rid itself of the horrible memories I carry of past abuse and ridicule from the mouths of my teachers, my parents, and my classmates?"

As Hannah approaches me, I immediately stand up and give her a welcoming hug. We haven't seen each other for months, because I've been so busy with nursing school and she with her teaching job. We sit across from one another at our table for two. Café patrons place their orders at the counter positioned behind us. We sign our conversation with our hands, bodies, and facial expressions.

Hannah can't hear the buzz of the café because she is deaf. And, I don't really hear it either as I'm captivated by the beauty of our common language. Hannah signs

to me about a recent field trip she took with her students to Multnomah Falls. She describes the falls to me. I watch her fingers flutter from her face toward her lap as she simultaneously releases a “Sh-hhh” sound through her lips. Bystanders in line stare down on us with curiosity and probable judgment, until they catch my eye then immediately look away.

After learning about Hannah’s latest adventures, she asks “How are things are going for you in nursing school?” I sign telling her about all the ups and downs I’ve experienced so far. I tell her about my everyday fears of failure, the tactics of the instructors who are trying to weed me out of the program, how there’s so much reading and never enough time to do it, and how I regularly use pictures and YouTube to try to make sense of all the reading. I continue telling Hannah about my exciting clinical experiences, and how I could have the worst day ever – a patient could poop, pee, or throw up all over me in clinical and it wouldn’t matter a bit, because I love being there and helping people no matter the challenges of the role.

“In fact, I wish all my learning took place in the clinical setting,” I sign. “That’s where I shine,” I continue. “I know that, and my clinical instructors say so too. It’s the interactions, the activities, the smells, and the sounds of the place. I need those cues, that stimulation.” I contrast the clinical setting with the classroom, “I hate written tests, because they’re not real life,” I tell Hannah.

“What do you mean?” Hannah asks using her hands.

“I usually have to write short answer responses based on a patient scenario. It’s difficult, because I always need more information. I’d like to know the patient’s facial expression, if the patient is crying, the tone of the patient’s voice, body

language, does the patient even have a face, you know? But those damn tests don't tell me shit about those things. In real life, my actions depend on my observations of the patient and our conversation," I explain.

"That makes total sense to me!" Hannah signs with a smile.

"Plus, you know I stink at reading and writing, so that doesn't help me on those kind of tests either. I always need more time to process written questions and express myself in writing," I tell Hannah.

Later in our conversation, I inform Hannah that I'm thinking about getting tested for learning disabilities to see if I can get accommodations for test taking.

"Oh yeah, last time we met you said you wanted to do this on your own?"

Hannah reminds me.

"I know," I respond. "But now I'm in a different place. I'm through the first half of my program – the hardest part. You know, I just wanted to test myself without the help to be sure that I could do the job. I have my own strategies for clinical now, and I think it's time I gave myself a break on the classroom stuff. I can't imagine not being a nurse. I mean, what would I do if I failed out of the program? I'm set on this path now, and I want to be the best I can be at this. I think accommodations might help me to survive it all."

"You know, I'm still nervous though about my instructors knowing, judging me, or thinking less of me," I sign, and Hannah nods with a certain understanding.

"They're not supposed to, but I see how they treat other students who have accommodations. I watch their reactions, their body language. I see the skepticism

and doubt in their facial expressions. I don't want to be thought of as stupid, you know?"

"Yeah, I understand, I deal with that daily," Hannah says.

We sign for another hour or so, wrap up our visit, hug goodbye, and I head off to school to suffer through yet another dreaded test.

A few months later, I'm tested for learning disabilities. The practitioner reveals the results to me.

"Cali, based on the tests and your description of symptoms, I believe that you have Attention Deficit Disorder (ADD) and Auditory Processing Disorder (APD). This is why you get distracted easily and have trouble understanding others in noisy environments," the practitioner explains.

"Yeah, that makes total sense," I say. "Things sound garbled sometimes and I can't interpret what others are saying when there are multiple conversations going on at once." The practitioner proceeds to tell me that I may benefit from hearing aids for this and medications and/or academic accommodations for my Attention Deficit Disorder.

Months later after all the appropriate paperwork is filed, I have a note taker for all my classes, a private room for test taking, and time and a half to complete each test. My grades significantly improve with these accommodations. My insurance plan doesn't cover the hearing aids recommended for me though. It takes some time to fight them on this, but eventually I do get them in the final year of my nursing program.

Now, in the senior year of my nursing program about six weeks into my final clinical practicum, I'm at home. I take my daily medication that helps me focus better. Then I fumble to position my new forward facing hearing aids on my ears. I style my hair in a fashion for maximum coverage of these new devices. After I carefully assemble myself, I head off to meet my preceptor, Diane, at the hospital for my shift. As I enter the unit, I'm extremely self-conscious about my hearing aids. I think about how I'll explain what auditory processing disorder means should someone notice my new accessories, and I fear the response I may get from some, like "What happened to your wiring Cali?" Forever hiding my disabilities in the clinical setting, I'm now acutely aware that they're on display for the world to see. Typically I feel at home in the clinical setting, but as I enter it today, I'm scared, face flushed, heart racing, and palms sweaty. I worry Diane will lose confidence in me if she uncovers my disabilities.

I perform independently through much of the day feeling quite productive, useful, and of value to the nursing team. With the end of my shift approaching, I find a quiet area of the unit so that I can focus on completing my charting for the day on time and without distractions. The time part can be problematic for me on some days, but I'm getting better at it each shift. Once finished with my documentation, I approach Diane for our usual end of shift debrief. As we discuss my performance, Diane says, "I think you did great with just about everything today, but I'm a little concerned that I don't see you taking many notes during the shift Cali, and I think you may be relying on your memory too much. I worry that if you get overwhelmed at any point, you might forget things."

“Diane, my memory is my strong suit,” I say in defense of my developing practice. I choose not to reveal to her my frustrations about taking notes – how I get fixated on the spelling of words. And, that I worry about others seeing my notes and thinking that I’m stupid, because I can’t spell very well. “Do you feel as though I don’t ask enough questions or something Diane?”

“Oh no, you ask tons,” she confirms.

“Well, do you feel as if I’m dangerous or overly confident – that I do things without knowing what I’m doing?” I ask.

“Oh, no, no, no, not at all,” she says. Given that we’ve worked closely together for a good 6 weeks now, I’m really puzzled by Diane’s observation.

“Did she notice my hearing aids?” I wonder. “Is this what’s prompting her out-of-the-blue concern?” Or, “Is this her way of giving me an opening to talk about my disabilities perhaps?” I don’t investigate Diane’s intentions, but simply reassure her that I’ll continue to jot down the most critical information throughout the day to keep my patients safe. “Keeping my patients safe is my number one priority,” I remind her. Diane seems fine with this for now and drops the topic.

Just before we part for the day, I tell Diane, “I really respect you and your experience, but sometimes I need to do things at a certain pace or in a way that works for me. I want you to continue to push me though, and to think about or try out other strategies too. I wanna be accountable and to know that I’m doing things right. I always appreciate your feedback.”

“I know, and I’ll keep pushing you to always be better,” Diane says with a nod and a smile.

As I leave the unit, I think about Hannah and our last conversation in the café.

“I should just suck it up and get over myself and insecurities already . . . But Cali, this is new ground for you,” I say in my mind, and then offer myself an excuse. “You have to be cautious in unknown territory. You don’t know what others think about people with disabilities in this setting.”

As I stroll away from the building, I wonder if I passed under the radar or not today. “Did Diane discover my disabilities?” I ask myself, “What if she did? What does that mean for my future on this unit – as a student or potentially as a new nurse?”

Arming myself

I enter the Student Health Center at the university in search of strategies that will help me to be a good student. I walk into the consultation room and await the practitioner's arrival. While I wait, I flashback to the scene that led me here today.

It's the last month of my paramedic internship, Mike, the lead instructor asks me to meet him in his office. I arrive and stand before him.

"You should report when you make a mistake Julie," he demands.

"A mistake?" I respond puzzled.

"You didn't follow the required medication protocol," Mike explains. Then he gives me some added context around the situation he's referring to.

"I gave the correct dose," I tell Mike in an attempt to defend my actions. "But what happened is that my preceptor told me to give a different dose. I just don't think I heard him or something. In any case, I looked up what I gave, and I think the dose I administered given the circumstances was also acceptable."

"Why do you want to be a paramedic anyway?" Mike asks facetiously. I have the sense now that he's on some kind of hazing venture. "Sometimes people just need a kick in the butt, and that's what this meeting is all about," he says directly in my face, blaringly. I apologize to Mike for my part in whatever happened in the field, but he doesn't seem to care. He goes on relentlessly attacking my spirit.

"I just don't get how your brain works. Are you slow or something?" Mike asks. "I bet you rode the short bus to school, didn't you? Get a clue girlie, this place isn't for you!" I sit in shock, clearly powerless in this moment, stunned by Mike's hurtful comments.

“You can’t test for the paramedic license,” he fires away. “You’re not hireable. You can’t hack this job.”

“What? What does that mean?” I ask.

“If you really want to do this, then you’re going to need to repeat all of the first year paramedic courses,” Mike says. “So good luck with that!” And, I am crushed.

After reliving this memory, I feel sick to my stomach. I try to coach myself toward calmness by reframing what happened back then. I remind myself that I was young and not the greatest student at the time. And, there were also a lot of programmatic factors that contributed to my failure as well. I think about how the clinical experiences in the hospital were helpful but it wasn’t real-world paramedic work. “I just needed more time in the paramedic job, the actual job I was going to be hired into after my schooling, and that just wasn’t part of the program,” I tell myself.

The door opens and I’m startled back into the moment as the practitioner enters the room, he smiles, and extends a hand, introducing himself as Daniel. He is a counselor.

“So Julie, what brings you in today?” he asks.

“I’m here to make sure that I’ve got what I need to be a good student.”

“Tell me about your concerns,” Daniel says to me. I don’t say it aloud, but I’m terrified to fail out of nursing school given what happened before.

“Well, I’m starting my first year of the nursing program, and I want to be sure that I do really well.” I hesitantly explain, “I had a bad experience in another program

before nursing that makes me doubt myself a little.” Daniel nods and offers a look of curiosity. I begin to feel a bit more comfortable in his presence now.

“Yeah, it was an awful situation, actually. I think I have a little PTSD about the whole thing, and I’m probably overcompensating due to that now.”

“Okay, so you want to do well this time around so you don’t encounter the same situation again?” he says summarizing my goal.

“Yes, exactly,” I reply. “And I want to be sure that I’ve armed myself with all the strategies and resources I need to do well in nursing school. I mean, I know I’m more mature now, and because of that I’ve made some different choices this time around that I think will help me be successful.”

“Tell me a little more about the choices you’re talking about,” he says.

“Well, right before I got into nursing school, I found out that I have ADHD,” I tell him. “So I requested certain accommodations that I think will help me in class and in test-taking. Other choices, hmm . . . I’m taking my ADHD medications consistently. I’m not working while in school like I did last time, and I’m living off of student loans instead. I’m maximizing the use of all the nooks and crannies of time I have. I listen to recorded lectures on my long commute to and from school. And, I’m keeping my extra-curricular and social activities to a minimum. I’ve basically prioritized my studies over everything else.”

“It sounds like you’re doing everything right from my perspective Julie,” he responds. I feel relief as a result Daniel’s assessment.

“Oh good, I just wanted to be sure. I have a lot of stress around failing,” I say. Daniel offers me some stress reduction strategies. Then, he tells me about a one-hour

mindfulness session on campus that's available for students Monday-Friday at noon from which I may benefit.

"Why don't you come back and see me after the mid-term, so we can talk again about how things are going and if the strategies you're using are working for you or not," he further suggests. I agree with this plan and Daniel prepares to move on to his next consult.

"Thank you for seeing me today. I really appreciate your help and reassurance," I tell Daniel as I leave the room.

Two and a half years later and with straight A's in all my courses I'm on the home stretch of my nursing program. As I'm finishing up the first term of my senior-year preceptorship experience in a Pediatric ICU, I am called to a meeting with my clinical instructor, my preceptor, and the unit manager to discuss the plan for my experience on the unit next term. As I head to the meeting room, I feel excited to talk to everyone about my progress and my goals for next term. Then, I flash back to Mike's face and that awful situation, and now I'm somewhat anxious and paranoid about this meeting. I don't know why, because up until this point, I've only received positive feedback from my preceptor, Kristy. I think to myself, "Sure, I'm not perfect. I'm working on things like everyone else, but there's no significant issue that I'm aware of." I wonder, "Did I miss something?"

I find the meeting room and when I enter I see all parties are present. Every face in the room is smooth - a collection of polished stones, completely expressionless. My heart begins to flutter. Finally, my clinical instructor, Collin, looks up and welcomes me to the meeting.

“Please, Julie, have a seat,” he says and points to one of the open chairs around the table. Terrified, I wait for him to start.

“Julie, we’re here today to talk about your performance this term and to discuss options for your clinical experience next term.”

“Yes,” I respond. “I’m excited to talk about all that I’ve learned this term and to tell you about my goals for next term on this unit.”

“That’s the thing Julie,” the clinical manager, Becky, chimes in. “We think you’re struggling on this unit and that you might be better off in an environment that is less acute. You know, someplace that’s a little less intense might help you progress more quickly in learning the role of nurse.” As I attempt to grapple with this news a dagger penetrates my heart and my entire being deflates. The word ‘struggling’ burns in my brain. It sounds like something huge and ominous. “Why hasn’t anyone said this before today?” I wonder, as I try to recover from this emotional blow.

“But I really think that I’ve been making good progress Becky. My communication is better than ever now,” I say. “I know in general that I over-talk, but I’ve created tools for myself to streamline how I communicate to patients, parents, and the staff. I’m getting faster with the usual tasks and prioritizing them. Per Kristy’s recommendation, I’m also working on making my handoff reports less detailed. I know sometimes I can be too detail-oriented, but really all of it, I’m trying to do better.” Before responding, Becky looks at Kristy who sits next to her suspiciously quiet.

“Yes,” Becky says. “Kristy has told us all about the work you’ve done here. We know you’ve made progress, but we think that you’re stuck now, and that you’ve

been stuck in the details since mid-term. It's just - you're not getting the clinical judgment piece yet. This floor is just too hard for you right now. I recommend an alternate placement for next term, somewhere that's less acute so that you can walk out of nursing school with a really solid foundation of the general role of the RN. Right now, I think you're lost in all the details and unable to grasp the big picture."

"Julie, we all have your best interests in mind here," Collin reminds me. "I know you really wanted to be on this unit again next term, but this is really for the best."

"Okay, well maybe you're right." I say knowing that I won't win this fight. Then, I wonder what is not being said here. I hear from shifts past Kristy's repeated feedback circling in my head, "Good job! You're making progress. Yes – you're improving." Now that I think about it, this feedback was all very non-descript. "Should I have been more pointed with Kristy over the term when asking her for feedback?" I wonder. A stiff lump builds in my throat and I fear I can't keep my emotions tucked in much longer. I feel betrayed, again. After the meeting concludes, Collin and I meet privately to discuss options for an alternate placement next term. I later complete my final term of the preceptorship in a long-term care facility without incident.

Finally, I graduate from nursing school with straight A's. I realize that I'm a good student now, but I wonder, "Am I equipped with the resources and strategies I need to survive real-world nursing specifically in an acute care setting where I want to start my new career?" I consider, "What do those A's I earned in nursing school mean in the real world anyway? I hope they mean something. They must." As I sit in

front of my computer searching for a nursing position that suits me – one that’s a fit for my strengths, Mike appears in my mind’s eye again. His words “You can’t hack it” carved forever in my consciousness. I feel the creep of new fears about this transition to work pile up inside me, and I wonder, “Am I hireable?”

Snipers & allies

In my new RN job for just three months so far, I am repeatedly beaten and bruised by the persistent criticism of my regular preceptor, Jan. My manager also believes that my performance is *delayed* compared to other new hires and that I need extended orientation time. Before heading into work this evening, I take a jog around my neighborhood with my dog, eat a little something, take my maintenance medications for Generalized Anxiety Disorder (GAD), and then prepare to go back to the job and face another torturous round of criticism. I wonder, “What does the universe have in store for me tonight?” As I contemplate the possibilities, I feel my insides getting worked up, my heart is jumping around in my chest, and there are butterflies moving about in my stomach. Anxiety like this rules my life and has since I was a teenager. To calm my nerves, I kneel on my bedroom floor, and with the door closed to the outside world I do my daily chant and meditation ritual. I work hard to visualize shades of grey, more possibilities than simply the black or white scenarios in my mind that aggravate my stress level and spiral me into either a panic attack or a deep depression depending on the day.

On my drive to the hospital, I try to reset my mind on the concept of hope. “I’ll get there eventually,” I reassure myself. “I’ll be able to do what they want me to. I just need the opportunity.” I arrive at the hospital at 10:30 PM. As I enter the unit, a feeling of dread encompasses me. I coach myself, “You can do this. No matter what criticism comes today, you will NOT quit Beth.” I channel a positive thought; “This will be the shift where I learn what I’m doing right in my practice.”

I get my patient assignment from the charge nurse on duty. My assignment is to take three patients tonight, and to practice efficiency in completing the admit process should the unit get a new patient during the shift. Upon review of the electronic medical records of my patients and the hand-off reports delivered by outgoing nurses, I consider the priorities for my shift, and I write them down so I can reference them later. “Please God no admits tonight,” I say to myself. I never get out on time when I get a new admit, and I don’t want anyone to hassle me about working past my shift if I need to finish up my charting. I recall my last experience in trying to complete a new admission. It was a lot of work. The patient was very unstable, had lots of pain, respiratory, fluid volume, and dietary issues, and required multiple tests both in and out of the unit. Not to mention, the attending doctor issued new orders about every five minutes. I just couldn’t keep up. I pose a question to my probable fate, “When that happens to me tonight, how will I manage and take care of three other very sick patients at the same time?”

Before checking on my patients at the start of my shift, I meet with Sally, my preceptor for the evening, to confer on the priorities I identified and my plan of action. Much to my relief, Jan, my regular preceptor called in sick today. I worked with Sally once a few months back before she went on maternity leave. This is her first shift back from leave, and upon our reintroduction, I perceive that she is happy to have someone to share the work with right now as she reintegrates to her job.

“Would you like to try this on your own tonight Beth?” Sally asks.

“Yes!” I respond with enthusiasm. My stress level immediately plummets with the realization that no one will be hovering over my every move and insisting I

do things their way. I consider, “This is just what I need - the chance to build some confidence in my own practice routine.”

“I’ll definitely come to you through the night if I need to clarify something or have any concerns at all,” I tell Sally as I head off to greet my patients. Sally agrees to this plan.

As my shift concludes, I’m feeling unusually confident in my independence and efficiency. I think back on my accomplishments of the night, “I kept all my patients comfortable. I managed their pain. I finished all charting and written handoff reports by 6:30 AM.” After taking a minute to pat myself on the back, my mind drifts to the dark side momentarily. I think about how my co-workers and manager perceive me as slow, unable to keep pace, a disappointing new hire in their eyes. The stress of it all makes me again queasy. The dread I felt earlier about coming to work overwhelms me temporarily.

Before I go in search of Sally to debrief our night, I prepare for the negative critique my regular preceptor, Jan, has conditioned me to expect after every shift. To counter the fears I have about what Sally might say to me, I remind myself of the things that I think I am doing well, “My charting is impeccable and my medication administration is top notch, because I’m very particular about checking and triple checking and doing all of that. And, my patients also seem to appreciate what I do for them.” I wish to myself, “Just one time – I want someone to notice the progress I’ve made – and comment on the good things about my practice.”

Sally and I sit down in the break room to talk briefly. I start our conversation by thanking Sally for having trust in me to do things on my own tonight. Then I proceed to share my self-assessment with Sally.

“My goal for this shift was to independently and efficiently manage the care of my patients and to reach out for help if uncertain about anything I was doing. I think I met this goal. What do you think Sally?”

“Yes, I think you did a great job Beth. I was tracing your steps through the night to make sure you didn’t miss anything – orders, call lights, nursing interventions, documentation, etc.,” Sally says. “From my perspective, I think you covered everything. I even observed that when you caught up on your work at one point you asked the other unit nurses if they needed help with anything. I noticed a couple of things that you could’ve done differently to be more efficient. There was nothing you did wrong though. I think with more time, you’ll find ways to be more efficient in your practice.” I pause and think about what Sally is saying.

“Yeah, I don’t know how things would’ve gone if I’d had a fourth patient or received a new admit. That, I know, would’ve been more challenging for me. I think I have a good handle now on the unit routine and usual tasks though. This was the first shift where I felt like I had my head above water and could look around and see what was going on. You know, the big picture.”

“That’s a huge deal – making that switch from focusing on the details to having a grasp on the big picture,” Sally says with encouragement.

“Yeah, I made a conscious effort this time to take myself away from those little things, tiny things, and delegate them out when possible and where appropriate

so I could really get a sense of the patient's experience from a different vantage point."

"That's really great!" Sally exclaims. That's good progress." Clearly ready to head home, Sally begins to gather her things and stands up to leave.

"That's what I think too, but everyone else thinks I should be further along by now in learning my role," I say disappointedly.

"You're a new graduate Beth, not an expert nurse." Sally pulls open the door and says over her shoulder; "Don't beat yourself up so much. You'll get there." I smile in response to her words, and we both exit the room and head for the time clock to punch out for the day.

Encouragement is so foreign to my experience thus far, I feel thankful today having not received the usual end-of-shift pummel to my ego and esteem. As I exit the hospital at 7:30 AM, I walk my usual path surprisingly calm for the very first time since starting this job. "Maybe I can skip my supplemental anti-anxiety med this morning?" I ponder. As I head to my car, I take a moment to notice the sunrise. It's beautiful - an added slice of joy in a very unexpected day.

A ticking time bomb.

I'm a wife, a mother of two children, and a newly licensed nurse. I'm doing my best as a spouse and a parent, but as a new nurse I fear I may be in the wrong place. On-the-job time travels at light speed, and I'm forever behind where I want to be. Only 15 days left of my orientation period in my first RN job and I'm starting to panic a little about that. I'm concerned I'm not ready to be on my own yet.

Now I lay in bed, tossing and turning, stressed by the clock, a ticking time bomb here that pressures me onward to a different task every minute of every day. Time is of the essence now – and how I wish for the vastness of time I had when I lived in Nowhere, West Africa. My mind drifts about as I try to go back to sleep, eventually it lands on a memory, an accomplishment borne out of time in another world. I enter the past in my mind.

It's mid-day, I think? The only way to tell if time is actually moving here is by the degree of heat I feel from the fiery sun. It scalds my pale white skin in just seconds on days like today. After working the farm all morning with the locals, I now lay on the concrete slab inside my open-air mud hut to stay cool. From my horizontal vantage point, I see goats and chickens roaming amidst the village. My dog Presto naps in a matted heap beside me. As I continue to stare into Nowhere, little girls pass by with armfuls of dirty laundry. I examine my raw, reddened hands and consider being American for a day and paying the girls a quarter to take care of my next pile. Others pass by my hut and I try to make out their conversation, but I only understand a word or two. They're speaking in a hybrid form of French – a grunting and tonal type language. I try to learn the language but it's hard because I struggle with reading

and I have difficulty hearing tones. The *people* person inside of me, unable to communicate much with these welcoming dark-skinned people is restless and bored, tired of staring off into space waiting for these expansive periods of downtime to pass.

I harness my thoughts and glance across my small living quarters at a stack of books I received by mail from my boyfriend a few weeks ago. At 23 years old, I've never read a single book before from cover to cover. I wonder about Jeff sometimes. He knows I hate reading because it's so much work for me with my reading comprehension disability. I ponder, "What was he thinking anyway?" With no logical answer in mind, I crawl my sweaty, antsy self toward the pile of books, and I pull *Pillars of the Earth* from the middle of the stack. There are about a 1000 pages between the front and back cover, and the print is very small. I close the book and stare into the village again thinking "Is this the day I'm going to read?" Presto groans and repositions himself. I open the book again and attempt to take in the first paragraph. I go back and re-read it again and again and again until it's imprinted in my brain. I continue this with each page until many days later I finally finish the book. I put the book back in the pile with the others. "Which one will I read next?" I contemplate. Here in the middle of Nowhere, a place where the hands of time have little meaning, I continue to read, and I enjoy it.

After reliving this memory, I find sleep through peace in knowing that I can accomplish great things with the right amount of time. A few nights later, I enter my house at 8:30 PM after a grueling 12-hour shift. My husband, Jeff, greets me when I appear in the kitchen.

“Hi Sweetie, how was your day? You look exhausted,” Jeff notices.

“Oh, it was the same as yesterday,” I reply. “Except a different day, different preceptor, different unit, you know the story. Time’s running out for me and I’m stressed.”

“Well” he says, “Is there anything you can do about the situation?” I sit down at the dinner table and place a fist under my chin to hold up my tired head.

“I don’t know,” I tell him.

“What about your boss?” Jeff asks. “Can you talk to her about having more time?”

“Yeah, probably. I’m gradually working myself up to it, trying to be okay with not being in time with the rest of the new nurses who started with me.” Inside my head I think for a passing moment, “Should I ask for more time or just quit?” In disbelief that this thought even entered my mind, I coach myself, “What are you thinking Meredith? You don’t break commitments, ever.” Jeff brings me back to our conversation.

“I think you need to do whatever is best for you at this point, and forget the rest of them,” he says. “This job is clearly taking a toll on you. I mean, good grief, you’re seeing a counselor now about all of this. Is this job really worth it to you?”

“I know, I’ve been thinking about that, but I’ve battled so hard to get here – every class, every degree. I know I can do this, I basically taught myself to read after all Jeff, remember?”

“I know,” Jeff says, “But you did that on Nowhere time.”

“Yeah, you’re right,” I say and nod in agreement. “But if I can make it just 9 more months without crashing and burning then I can look for something different. I promised them a year, you know.” Jeff shrugs and rolls his eyes, knowing he can’t change my personal policy on keeping commitments.

With our conversation at a standstill, I head upstairs and check on my two girls. They’re tucked into their bunks and sleeping soundly already. Taking in every ounce of their preciousness in this still scene, I assert in my mind, “I can be both the parent and the nurse that I want to be – I just need more time.”

My eyes close for the night and re-open at 5:00 AM as the alarm jars me awake. Although it feels like I’ve only been asleep for 15 minutes, I get up, shower and dress. Before I kiss my family goodbye, I assure them that I’m all theirs for the weekend. As I make the hour commute to work for my final 12-hour shift in a string of three, back-to-back, I rehearse over and over the conversation I’ll have with my supervisor later today about extending my orientation time.

Three hours into my shift, I’m on a break, and I notice Sue is in her office. I peek around her door and say, “Hi Sue, do you have a minute to chat?”

“Sure, come on in Meredith,” she says welcoming me into her space.

“Sue, I want to talk to you about my orientation,” I begin confidently. Sue leans in on her desk with a certain amount of curiosity.

“Oh sure, I noticed that your end date is coming up,” Sue says.

“Yes, that’s true,” I say. “But I need to tell you that I’m not feeling ready to be on my own yet. I want to know that I’ve really got this down, that I’m safe in this role so I don’t harm anyone. I don’t feel like this where I am yet.” Sue looks at me

somewhat deflated by this news, but I manage to stay strong. “What’s the possibility of me getting more time in orientation?” I ask her.

Sue sits back in her chair with her arms folded in front of her slender frame, and as the clock ticks I await her response, mindful that me keeping my commitment is dependent on Sue’s understanding of time.

Adrift.

A flash of dark brown, a little yellow, now just a bit of purple there, right in the middle. I apply my color pencils to this task. It tastes like a moist chocolate cupcake with vanilla icing. I hear the soothing sounds of a classical guitar. Then, a sugary sweetness infiltrates my sinuses as I continue to work my way through this medication calculation. This is my synesthesia at work, or the automatic and involuntary crossing of my senses. I have trouble seeing numbers, so I do math using colored pencils. This helps me make connections between numbers and musical patterns. The colors stimulate in me sensations of sound, taste, and/or the smell of different things. Through these sensational processes and musical rhythms I find the solutions to mathematical problems.

The sensations intensify over the next few minutes. I hear a saxophone and then an electric piano. Heat is all around me. I begin to corral the numbers, tap my feet on the floor. I see it now – the sequence. There’s the number two and it’s red, the three is cobalt blue, the four is chartreuse. A jazz tune comes alive in my head. Then, finally I complete the problem. “Voilà!” I say aloud to myself. I look up at my peers in study group sitting around the table with me. They are silent, staring at me like I have three heads.

“Josie. Really, an idiot could understand that equation,” Roger says. “What took you so long?” I think carefully before I reply in front of the group.

“Do you remember how we were talking about disabilities the other day in theory class, and how some go unseen?” I question him hesitantly.

“Yeh, so what?” Roger says flippantly.

“Well, I have one, you know, a learning disability,” I disclose.

Roger’s mouth falls open and the rest of the group physically cringes. Some even grimace and push themselves back from the table in either fear or disgust, it’s hard to tell.

“I know you guys, this is very scary stuff,” I continue sarcastically. “What in the world could it possibly be?” I make a scary oooohhhhh-ahhhhhh noise, crinkle my nose, flutter my fingers in front of my face, and before anyone can respond, I turn more serious in my tone and assert, “It’s dyscalculia.”

“Like, what’s that?” Justine leans in and asks me.

“I can’t see numbers sometimes, so I’ve gotta do extra stuff to make sure that I get them all to where I can see them,” I say, keeping my explanation simple for them. This is me sticking my big toe in their world. At this point, I don’t dare dive into an explanation of my synesthesia until I assess their reactions further.

Roger interjects, “Are you afraid of being a nurse then?”

I reply, “No. I’m certainly not. I’m afraid I’ll make a mistake like everyone else, but I work a lot harder so I don’t make them.” The group is silent momentarily, and Alicia, our informal group leader, redirects us back to the task of studying and quizzing one another for our upcoming test. As the group carries on, I note that some of the members start talking to me in simpler terms.

“You know guys, I’m not stupid,” I blurt out, annoyed.

Today I’m adrift. It’s six months since I received my nursing license. I’m on a raft, alone, on a crystal clear body of blue water. “Were my classmates right to be skeptical of my abilities?” I consider. “I’m 40 years old, 40 thousand dollars in debt,

and unemployed, definitely not where I thought I'd be at this point in my life." The slight ripples forced by a mechanical current push my raft ever so gently up and down. As I swirl aimlessly about, my purpose drifts further and further away from me. I throw my head back to wet my hair, and I notice the sun is beginning to peek out on this overcast morning.

The sun's heat begins to dry the beads of water on my exposed skin. I feel a tingling sensation as the evaporation continues. My mind floats to an exchange I had with Martha yesterday. She's a friend from work, an experienced nurse who's been an informal mentor to me since I started working as a new nurse. I invited her to come by for lunch. We'd originally made plans for a dinner date, but since my day unexpectedly opened up, I rescheduled so we could meet earlier and spend more time together. Swirling about on my raft, I recall our conversation from yesterday.

"So, how's job hunting going?" Martha asks.

"Well, it's pretty slow." I say. "I don't know what I'm doing wrong. I've applied to everything under the sun, even stuff that I'm not qualified for." Martha nods with empathy in her eyes.

"I think it's just that most places want a minimum of two years of nursing experience, and I've only got four months under my belt so far. I did get a call yesterday though about a possible interview."

"Well that's something, right!" Martha exclaims.

"Yeh, I'm not super excited about it though," I admit. "It's not for a job in a hospital. So, that's disappointing. Also, I'm still trying to figure out how to respond to the big question. You know, they're gonna ask it. I mean what am I going to say?"

I reposition myself on the raft and then gaze to the sky. I take in the formation of the billowy white clouds above now beginning to separate. Then, my mind flashes back to that fateful moment, AGAIN. I see a movie playing in front me. There's a firing squad of nurses, educators, and managers on screen opposite a fearful nurse, seemingly caught off guard. Each member of the squad holds a weapon in hand. The manager raises her gun and fires at the innocent nurse opposite her. The nurse takes a direct hit in the gut. Dark red blood gushes. I smell dahlias and hear sounds of a flute whispering a tune in the distance. The educator fires her round on the nurse. As this scene plays out in my mind's eye, a pain pierces through my head. I feel queasy as the nurse falls to the ground. My heart races, fearing what I know is about to come next. Then as I predicted, the preceptor fires again. The silver bullet travels in slow motion straight for the nurse's heart. I smell wet ashes from an old fire; a trumpet plays Taps flawlessly in the background now. I freeze in time, motionless.

My mind next brings me back to the kitchen and the exchange I was previously engaged in yesterday with Martha. "Well, what will you say when they ask you the big question? Martha asks.

"I really don't know yet." I say. "I'm still angry and bitter about the whole thing, and I don't want that to come through for sure. Since my dismissal from the unit, I still feel like a failure. It still hurts to know others thought that I couldn't do the job. It's just not true, and I'm sick over it."

"You did the best you could do under the circumstances though, right!" Martha replies. "You have to remember that," she says with encouragement. "You know, my opinion ought to count here too. We worked together for four months. I

watched you work. You did the right thing. Safety first, always! You were more careful about your practice than anyone else on that unit. I know, I've been around and seen others speed through their work and make mistakes, big ones! So, being cautious in your work is a really good thing," she reminds me and continues, "I've seen others before you get dismissed for worse things than trying to keep their patients safe. You had your priorities straight, it's unfortunate management couldn't see that."

"Yeh, I know." I say. "They just expected me to do things faster. To do what they wanted, I would've had to cut a lot of corners. They didn't understand, or even care to try to understand my intentions. It's just I have a system and I have to do stuff a certain way to keep things safe for everyone. I have to do my double and triple checks, always. You know, this is why I've never made an error, I'm sure of it. I think I would've gotten faster eventually, but I'll never, ever compromise that - the safety of my patients. I have to work at a pace that's safe for me." Martha nods her head vigorously in agreement.

"I hear ya sister! They expect too much of us and they give us few resources to work with. I'm nearing the end of my rope with that place too. I'm sick of the system running over my practice to the point that I can only give mediocre care. It's too much, and I don't like how it feels at the end of the day! I wish management could see beyond the dollar signs that drive them in their decision-making."

Returning to the moment, I stick my hands in the water at the edge of my raft. The sparkling liquid is now cooler than the air. I smell the scent of freshly sprayed Windex. The day is heating up my body. To give my raft a bit of momentum forward

in the stagnant, humid air, I flap my hands in a paddle-like motion until it begins to travel on it's own. I rest my head back once again and stare up at the sky vacantly. One of the clouds reminds me of a cat I once knew from my childhood. Her name was Charmin. I see her image in my head, and I taste a meringue pie, slightly sweet, yet tart on the finish. I hear Charmin purr like a car engine in need of a tune up. Charmin was our family cat.

My mind enters the past. I am little, six or seven years old maybe. I run straight from school to home. When I enter the house, I yell, "Mama, Mama!" over and over.

"Come in the living room princess," she shouts. I enter the room breathless, and I see her on the couch buried under a couple of blankets. "What's all the fuss about little one?" she asks me.

"Some of the girls in school today were picking on me," I tell her trying to hold back tears of shame. "They called me Josie-Grossy because of my birthmark!" I shout with a red face; then tears begin to stream from my eyes uncontrollably. My mom pulls me up onto the couch with her. I cry into her skeletal body. As I heave and gasp for air, she rubs my back gently in a circular pattern. After a few minutes of consolation, my breathing slows. I turn my thoughts to mom now. I know she's sick. I can feel it as her heart beats into my ear. There's a sour taste on my tongue. I look up and into her face for a moment. Her mouth has shrunk to the size of a quarter and her hair is all gone. She has many scattered sores on her body, several covered by Band-Aids or larger wraps held by cloth tape. As I take in her face, I see a pale peach blur and hear a foreboding cello song amplifying in my head. I feel mad thinking about

how others see her as a monster and call her mean names, just like those girls at school do to me. I don't understand, but it is my goal to save my mom. I turn my eyes downward and inspect a bandage that covers most of her belly. I don't know what's underneath it, but one time my mom told me it was like a spoiled grapefruit growing inside her.

“Mama, I think if you just get that cut out, you'll be fine and you'll get better,” I say.

“Now Josie, that's not how it works,” mom reminds me. “If they cut it out, I'll need a lot of skin to cover the hole.”

“Well, if I die, I want you to get that removed and you can use all of my skin to cover that, okay?” I ask my mom with some frustration given our limited options.

“Thank you sweetie. Now, could you get me some water pretty please?” Mom asks. I oblige wanting to do whatever I can to keep her alive. I very carefully bring a full glass of water from the kitchen to the living room, and I place it within arms reach of her.

“I'm going to be a doctor or something,” I tell her. “So I can figure out how to cure you. I'll save you.” This, a regular assertion I repeat to her daily.

“Doctors, they don't get to see me that much. You know, nurses do,” mama points out. “Yeh, I get to spend all my time with nurses, and they help me.” As this new information sinks in, I stand up tall in front of my mom and look into her scarred face and sunken blue eyes.

“Well then I'll be a nurse,” I exclaim! “That's what I want to do. I wanna care for you.”

WHOOSH! SPLASH!! I find myself abruptly back in the present. My raft is bouncing now out of control. A young boy then surfaces next me in the rough water, coughing and laughing simultaneously.

“That was my best one yet!” he shouts. “You didn’t even see it coming, did you?” he asks. I reorient myself quickly to time and place.

“Yep, you got me! That was a 10 for sure!” I say calmly, trying to downplay the fact that the cannonball the boy performed upon his entry to the pool scared the holy crap out me. I get out of the water, dry off a bit, and situate myself on a lounge chair in the sun. I watch the boy swim laps now in the pool, and my mind drifts for another moment back to the memory of mom. I close my eyes, and I feel her spirit all around me. I think, “She didn’t have an easy life. Cancer robbed life from her when she was just 29 years old,” I remind myself, “I’m adrift right now, but my purpose hasn’t been stolen. My dream is to be a nurse in a hospital taking care of others in this world who need it.” I push aside the words of the naysayers and doubters from my past. “I’m still going to try to do that, eventually,” I coach myself.

Finally dried out by the sun, I leave the pool area and walk back to my apartment. As I begin to reset my intentions on my purpose and calculate my next move in this battle, I realize my first task is to decide how I’ll answer the big question in the job interview tomorrow at Stafford General Hospital.

Interpretive Summary of Findings

In this study I sought to describe the experience of students and NL RNs with learning disabilities in transition to practice, and to identify the structures, processes, and belief systems in the life histories of these individuals that potentially contribute to inequities in their TTP experiences. The stories presented reflect the primary archetype of the hero. That is, a character who, in most situations seeks to do good and/or accomplish great things, but encounters a roadblock of some type, an evil that attempts to steer her otherwise (Campbell, 2008).

Most importantly, all participants sought to perform the role of the nurse safely and competently. In the stories, the primary barriers standing in the way of each protagonist's attempts to do this were (a) people - bullies and others who misunderstood the hero's intentions, (b) exclusionary pedagogies, (c) misinformation, untimely information, or a lack of information, and (d) prescribed time constraints. The protagonist in each story attempted to counter these barriers through varied acts of courage and resilience.

Ideologies of ability in the context of social life, nursing education, and practice and the resultant bias, discrimination, and stigma participants' experienced related to their disability identity curbed their self-confidence and self-esteem at various points during their life courses. Encountering and managing repetitive low points in life, including experiences of horrific mistreatment and failure, forced these participants into survival mode. For participants, certain positive and negative events experienced in their histories were turning points that led them to nursing. All participants reframed their past experiences of abuse, neglect, failure, and disability

as learning opportunities or “object lessons” providing them with clues and insights about themselves as individuals and how they wanted to be and be known in the world. This perpetual reframing of negative experience fostered in these participants a spirit of resilience.

Participants, as evidenced by their histories, experienced major set-backs during their lives, which they overcame or learned to manage to survive and eventually arrive in nursing. Constructs of ability (e.g., GPA, writing skills, sociability, test-taking, and timed skills demonstrations), barriers that marginalized this group in gaining access to nursing and/or progressing through the battle, fueled participants’ courage to prove themselves capable of surviving nursing. Once in program, participants, though fearful of not making it through, went to great lengths to set their egos aside, fearlessly testing their abilities and self-management strategies in new situations. Though participants sought a certain level of personal perfection in classroom and clinical settings, all realized that they were human, and therefore imperfect. Moreover, in testing themselves in new situations, participants demonstrated courage in accepting the vulnerability of their humanness – they understood themselves to be

perfectly imperfect. Knowing

Real courage is when you know you're licked before you begin, but you begin anyway and see it through no matter what. - Harper Lee

full well that to err is human, these participants demonstrated caution in high risk patient care activities and consistently strategized their moves within the clinical setting to prevent error.

Integrity is a core value of the nursing profession (American Nurses Association [ANA], 2015). With this in mind, the findings of this study prompt the

questions: (a) What are the essential abilities one needs to be a safe, effective, and competent generalist nurse who practices with integrity? (b) Does courage and resilience fit or not within our profession's current construct of ability? (c) Are courage and resilience abilities upon which nursing ought to capitalize? (d) If so, how ought we redefine our current definition of ability in nursing and alter related structures and processes to tap into the courage and resilience of future nurses?

Chapter 5: Discussion

In this chapter, I provide a summary of the study and findings. I situate the findings within the existing literature on disability, TTP and resilience, and meanings associated with that of a *good* nurse. Then, I identify implications and opportunities for improvements in nursing education, policy, and culture. Upon acknowledging the strengths and limitations of the study, I offer a summary of final thoughts about this project.

Summary of the Study

In this study I aimed to: (1) Describe the situated experiences of individuals with learning disabilities (LDs) in transition to nursing practice (TTP) pre- and post-licensure, and (2) Examine the structures, processes, and belief systems embedded in the life histories of individuals with LDs that contribute to inequities within their pre- and post-licensure TTP experiences in nursing. I used a narrative life history method informed by Riessman (1993), Denzin (1989), and Cole and Knowles (2001) to collect, analyze, and interpret data gathered during this study. I also applied the disability studies model (Siebers, 2011) to aid in critically interpreting the lives of participants and the stories they told. Participants within the study sample included nursing students and newly licensed nurses (NL RNs) who were at different time points within their trajectories of TTP. These students and NL RNs were all women, yet diverse in age, pre-nursing educational backgrounds, and life experiences. I collected data primarily through 1:1 interviews with participants. However, I also reviewed various artifacts including course syllabi, learning activities, and job descriptions to foster contextualization of participants' experiences as well as for

purposes of data triangulation. Data analysis began upon data collection and continued throughout the project and into the write up of findings. I analyzed data at multiple levels of abstraction via various forms of coding, within-case analysis, cross-case comparison, and memoing about code definitions and broader themes as they emerged. Analysis resulted in the core narrative of *The Battle of Becoming*.

Description of TTP experience.

The main concern of participants was *becoming*, or changing or transitioning from a lower level of potentiality to a higher level of actuality (Collins English Dictionary, 2015). In general, participants believed society undervalues people with disabilities due to negative stereotypes and misinformation. As such, participants sought to become recognized and accepted as productive members of society through a career in nursing. However, societal ideologies of ability intermittently discouraged them from pursuit of this goal. Specific to TTP, each participant's primary objective was to become a competent, effective, and safe nurse.

To ensure this level of practice, participants' demonstrated multiple acts of courage. Participants demonstrated courage via their efforts to advocate and/or defend themselves in situations that compromised the integrity of their pursuit. They also showed courage in claiming their disabilities and related learning struggles and in seeking out resources for self-management. As well, participants acted courageously by testing themselves and accepting vulnerability in foreign situations. Moreover, in the face of uncertainty they intentionally requested reinforcing and redirecting feedback from others for purposes of critical self-reflection and ongoing self-improvement. For some participants, courage was otherwise expressed in an

admission of defeat in certain situations and in their ability to remain optimistic and open to new possibilities as a result of such experience.

Resilience was also a key feature of participants' experience in the battle of becoming. *Becoming* was non-negotiable for this group. All sought with intention to overcome histories of living "outside the box" and not feeling good enough or not feeling appreciated by others for their uniqueness and potential to contribute to the world in positive and productive ways. Participants embodied resilience through natural optimism and a consistent practice of reframing low points in life as learning opportunities rather than definitive setbacks. As such, all participants were poised by their life histories to battle the stigma, discrimination, and/or marginalization they encountered as learners and/or practicing nurses in their TTP experiences.

This study, via the vantage point of those with LD, also illuminated certain belief systems held within academia and practice about what it takes to be a *good* nurse. Participants' stories revealed, from the perspective of the academy, to be a good nurse one must excel at reading, writing, mathematics, and written and simulation-based test taking. One must also be able to demonstrate excellence within these areas in traditional practice settings like medical-surgical care areas and under specific time constraints, power-differentials, and within the confines of certain environmental and socio-cultural nuances. Excellence in these areas is demonstrated via a high grade-point average, and for many a high GPA is believed within nursing academia the primary indicator of one's ability to become a good nurse. However, once granted admission to a nursing program, one must also be able to perform up to faculty expectations, nursing skills expected of a generalist nurse. Here, a generalist

nurse is defined as one who can apply theoretical learning to clinical practice across multiple and diverse care areas from hospital- to community-based settings.

The results of this study also revealed embedded belief systems relevant to the new nurse in practice. Per participants' stories, upon licensure, a new nurse is considered likely to be a *good* or *abled* nurse if she conforms to the clinical practices of those who are training her. One is also considered *abled* if she communicates succinctly, yet thoroughly, and is in synch with a time-based norm or expectation about practice independence. Participants' stories further revealed that good nurses are those who respond to clinical demands in a timely manner and swiftly complete essential tasks including medication administration, the implementation of physician orders, documentation, and the admission of new and complex patients to their respective units. It was also clear from participants' stories that many preceptors hold a belief that NL RNs ought to have upon transition to practice, and no matter prior experience, a grasp of the "big picture" and reasoning skills needed to make important clinical judgments about patient care.

Participants' stories demonstrate differing views between academia and practice about what it means to be a good nurse. Faculty expect nursing students to display first and foremost academic excellence upon entry to program and thereafter in the classroom. Then, throughout their educational experience, students get snippets of time to apply their theoretical learning in varied practice settings primarily via structured learning activities. Except for the final year preceptorship experience, rarely do students fully immerse in the role of the nurse. Conversely, our practice partners expect NL RNs to hit the ground running via the simultaneous performance

of thinking and doing in highly nuanced, complex, fast-paced, chaotic, and often hostile clinical settings. These disparate foci between academia and practice in part contribute to the turmoil experienced by typical NL RNs in TTP (Freeling & Parker, 2015; Martin, Nelda, & Walker, 2015).

Despite crossing paths with powerful people, systems, and hegemonic belief systems about ability, participants in this study sought to maintain the integrity of their developing practice despite adversity, consistently demonstrating an awareness of risk and safety in all their clinical actions. The participants in this study employed life-long habits of courage and resilience to push their way through roadblocks that compromised their ability to stay true to the way in which they conceptualized their practice – that is, safe, effective, and competent. In doing so, the students and NL RNs in this study illustrated in varied forms their professional accountability as decision-makers in patient care and their obligation to preserve the integrity of their practice as explicated in the ANA Code of Ethics for Nurses (2015).

Situating the Findings in the Current Literature

In many ways, the experiences of participants in this study confirm those discovered in previous nursing research (Illingworth, 2005; Kolanko, 2003; Morris & Turnbull, 2006; Morris & Turnbull, 2007; Price & Gale, 2006; Ridley 2011; White, 2007). Participants in this study corroborated that having LD (disclosed or undisclosed) compounded their TTP experiences in nursing school and the workplace. They provided illustrative examples of struggling and battling to remain in their programs and/or new nursing jobs. Participants in this study similarly revealed issues specific to disclosure including fears of misjudgment, discrimination,

and differential treatment. As well, exclusionary pedagogies and workplace practices were also a part of participants' experiences. Similar to other research, the participants in this study wrestled with the desire to be autonomous in learning and practice, while at other times they sought and accepted assistance to assure forward progress toward their goals. Likewise, all revealed that disability diagnosis and/or personal recognition of disability was for them a critical turning point in their lives that enhanced their self-awareness, critical reflection, and ongoing personal development. The participants in this study, like those of prior research, reiterated a heightened awareness of risk for medical errors and offered examples of self-management strategies used to minimize the risk including double- and triple-checking of work, reading and re-reading critical information, minimizing distractions, and anticipating worse-case scenarios and responses to them. As well, prescriptive time limitations impacted this group in both classroom and clinical settings provoking anxieties and other emotional responses that further interfered with their learning. Similar to prior research findings, the participants in this study also identified positive influences of disability. Many believed they were holistic thinkers and described themselves as determined, diligent, creative, empathetic, humorous, honest, hardworking, and tolerant.

This study was the first, however, to consider the experience of students and new nurses with LD in TTP. Moreover, this study extends the current science on LD in nursing. It also advances current knowledge about TTP, re-conceptualizing it to include admission to nursing school and the pre-licensure period as well. The core narrative revealed via this study was the battle of becoming. The enemy involved in

the battle was the ideology of ability. Participants' illuminated ways in which the battle might be resolved relevant to TTP experience. They identified key factors that minimized anxieties and optimized their learning potential both pre- and post-licensure. Most felt comfortable in TTP when they had: adequate information and/or orientation to new environments including culture/norms/team member roles and nursing priorities; access to supportive faculty, preceptors, and peers receptive to alternate learning spaces and forms of acceptable practice; opportunities to test self-management strategies in new situations; extended time to develop and implement additional compensatory techniques where needed; time for reflection and debriefing of day-to-day experience; receipt of balanced feedback supportive of ongoing professional role development; clear performance expectations with knowledge of the objective criteria upon which their performance would be judged; access to nursing role models and mentors who self-identify as having LD; and the invitation to disclose learning complications and reasonable solutions to nurse educators or supervisory staff without fear of retribution. These factors at the crossroads of TTP and LD have the potential, when missing, to exacerbate disability and prompt in others misjudgment and doubt about the ability of persons with LD pursuing careers in nursing. This was often the case in the TTP experiences of participants in this study, and in turn fueled acts of courage and resilience by members of this group in the battle of becoming.

The disability closet.

Similar to findings of prior studies (Morris & Turnbull, 2006, Ridley, 2011), disclosure of disability was a decision point for many participants in the current

study. Where there is the existence of the closet, there is inherently the presence of marginalization and oppression. The disability closet perpetuates negative attitudes about difference and it regulates information sharing beyond what an individual may desire in terms of disclosure or secrecy (Siebers, 2011). Historical and relational discourses inform constructions of disability identity and such constructions impact patterns of disclosure (Evans, 2013). For example, levels of anticipatory fear and/or resistance to certain discourses about *being stupid, slow, or lazy* impacted whether or not the participants in the current study chose to disclose disability to their nurse educators or peers. In certain cases participants intentionally hid their disability in the closet. Some were on a personal quest to be seen and judged based on their true merits rather than their disability label. Consistent with the literature, others hid their disabilities based on the stereotyping and discrimination they had previously experienced in education (May & Stone, 2010) or based upon recent observations of nurse educator and peer bias toward persons with disabilities (Aaberg, 2012; Evans, 2013; Matt, 2011, Tervo, Palmer, & Redinius, 2004).

Conversely, some participants did not want to hide their disability identity, but found themselves imprisoned in the closet (Siebers, 2011) by nurse educators who either misunderstood their role in supporting students and new nurses with disabilities or who were, for whatever reason, unable or unwilling to open the closet door and reach in. Some participants in this study also chose to *pass* (Goffman in Siebers, 2011), or attempted to assimilate to a socially constructed norm, even at the expense of their own wellbeing. For example, some thought they might benefit from certain accommodations, yet sought to figure out how to manage on their own, sometimes to

the detriment of their own emotional health and/or grades. Others navigated a repetitive process of coming out, embracing a disability identity (Evans, 2013) to potentiate the achievement of their goals and/or to foster new narratives on disability (Green, Davis, Karshmer, Marsh, & Straight, 2005) with others.

Disability stereotypes, identities, & consequences in TTP.

A label of learning disability suggests that one has certain traits that differ from the norm in ways that have social significance (Green et al., 2005). “Stereotyping is the assignment of negative attributes to socially salient differences. Stereotypical differences are differences that matter and are also deemed by others to be undesirable” (Green et al., 2005, p. 197). Disability in society is negatively valued and tends to be something that others dread acquiring (Green et al., 2005). Through the lens of the medical model, individuals with LD are believed incompetent, disordered, dependent, and passive (Goodley, 2005). Those among the abled sect sometimes feel sadness or pity for those with disabilities. Such feelings can result in social awkwardness and/or relationship avoidance between those who are perceived abled and those who are not (Green et al., 2005). In TTP, a stereotype of *low ability* (May & Stone, 2010) was raised in situations where participants were unable to function per nurse educator or organizational beliefs about what it means to be a good nurse. However, the results of this research also support wide variations in disability-specific stereotyping by nurse educators as well as the attitudes they hold toward persons with disabilities (Aaberg, 2012; Matt, 2011; May & Stone, 2010; Tervo et al., 2004). As per participants’ stories some nurse educators were more inviting, accepting, and supportive of their learning differences and needs than others.

Within nursing there appear to be two prominent identities specific to one's disability label. The first is an identity of otherness (i.e., marginalization) and the second is one of being *at risk* for failure or error (Evans, 2013; Read, Vessey, Amar, & Cullinan, 2013). In terms of accessing needed academic or clinical support, individuals pursuing nursing as a career have just two options of which they may claim just one – abled or disabled. There is no in-between designation. Laws like the ADA (2010) with the Title III Regulations (ADA, 2010) serve to protect those with disabilities from illegal discrimination and to provide them with equal opportunity in learning. However, such law also perpetuates a divide and power-differential between those who perceive themselves as abled and those who are othered (Green et al., 2005). In other words, a label of disability is an assignment of difference - or 'abnormal' and is a social class indicative of a 'less than' status.

Labeling fosters *felt* and *enacted* stigma (Green et al., 2005). Participants in this study experienced *felt* stigma as a result of varied implicit and explicit communications or relations with others that illuminated their status as negatively different. In this study, *enacted* stigma occurred as a result of the imbalance of power (Green et al., 2005) that exists between nurse educators and students in the academic and clinical setting and between nurse educators and/or managers and newly-licensed nurses in the workplace. As such, some participants in this study experienced targeted discrimination by nurse educators and believed it was intended to thwart their participation within the nursing profession. For example, discrimination was illuminated via participants' reports of academic and workplace incivility (Gallo, 2012; Luparell, 2011), including insidious threats made by nurse educators about

participants' probable future failure. Despite securing ADA (2010) protection from illegal discrimination via formal disclosure, some student participants experienced both overt and covert forms of discrimination based on their loss of normative status in claiming disability per policy requirements. As such, the law presents a conundrum with regard to disability designation and does little to promote political, cultural, and/or pedagogical change that might enhance the inclusivity of all learners (no matter their learning diversities) in nursing education and practice.

TTP & resilience.

Participants in this study revealed through their life histories a resilience or survivor-factor in TTP management in both the pre- and post-licensure periods. There are a variety of definitions and conceptualizations of resilience, some dating back to the 1800s (Fletcher & Sarkar, 2013). The most common definition indicates that it is one's ability to bounce-back from traumatic life events or adversities and reintegrate after disruption (Richardson, 2002). The construct has been studied across disciplines; however, it is most often debated within discourses of adversity and positive adaptation (Fletcher & Sarkar, 2012). Scholars and theorists have diverse views on the nature of resilience. In varied forums it has been claimed a personality trait (Connor & Davidson, 2003), a process that changes during a life course (Luther, Cicchetti, & Becker, 2000), a coping mechanism to counter environmental stress (Fletcher & Fletcher, 2005), the product of context (Goodley, 2005), and/or a communicative process that potentiates the construction of new narratives of normalcy (Buzzanell, 2010). Participants in this study had different thoughts on the

root of resilience in their own lives; nevertheless, they *lived* and practiced it throughout their histories as well as in TTP.

The literature suggests that nurses need a certain level of personal resilience to survive the everyday work of nursing (Jackson, Firtko, & Edenborough, 2007; Moran, 2012), and it is particularly crucial for those functioning in unpredictable health care settings like acute care (Hodges, Keeley, & Troyan, 2008). As evidenced by participants' stories, TTP by its very nature is full of adversity – daily confrontations with stress, trauma, hardship, and difficult situations (Jackson et al., 2007) that occur in both the pre- and post-licensure periods, and in some cases intermittently mimic war-like conditions (McQueen, 2004).

It has been theorized that negative life events impede positive adaptation (Luther et al., 2000), yet others assert that adversity, in moderation, may set one up for mastering future obstacles (Meichenbaum, 1985). This study supports the latter as participants' confirmed via their stories that years of combating and learning to manage various educational adversities and other trauma and/or setbacks in life better prepared them to manage the shockwaves of specific pre- and post-licensure transitions in nursing. Also consistent with the discourse on resilience, the participants in this study inherently reframed or re-narrated negative life events or failure experiences as opportunities for learning and personal growth. They crafted new normals via the downplay of negative feelings and the foregrounding of positive emotions and optimism (Buzzanell, 2010; Goodley, 2005; Jackson et al., 2007). This was a primary strategy demonstrative of their resilience and one that was critical to their survival through TTP in nursing (Tugade & Fredrickson, 2004).

Nursing's current conceptualization of TTP is limited to the post-licensure period. The nursing literature primarily focuses on the TTP experiences of new nurses in practice and risks related to failed TTP. Economic costs and the increasing attrition of NL RNs from their first jobs within the nursing profession have lent to a recent trend in the development and implementation of new graduate transition programs and/or residencies (Spector et al., 2015). The NL RNs in this study corroborated that such programs are few and far between (Spector et al., 2015) as none in this group were offered such opportunity. Organizations with TTP or residency programs have been created and implemented to minimize attrition of new nurse populations and promote safe practice via the provision of structured education, precepted experiences, and intentional feedback mechanisms. Such programs are intended to support NL RNs competence and confidence during the first year of practice and are assumed to reduce job adversities and work dissatisfaction (Spector et al., 2015). Though there is some evidence that these programs improve NL RN job satisfaction and overall retention (Spector et al., 2015), little is actually known about the root cause(s) of transition success.

As evidenced by the study herein, resilience was a primary success factor in surviving TTP for nursing students and NL RNs with LD. The participants in this study were concerned with finding solutions to academic and work stresses like time constraints, interpersonal relations, and the lack of role clarity, organization, structure, and time in learning their roles. Despite the multiple adversities the student participants in this study faced, they repeatedly confirmed their desire to continue their fight to stay in nursing. As well, rarely did the NL RNs in this study speak of

having any intention to leave their new nursing jobs despite daily interpersonal or system-level discouragements. Even though some made time-based employment commitments upon hire and later realized their jobs were ill-fitting (Hodges et al., 2008), they remained unwavering in their self-determination to fulfill their commitments. This finding counters the literature relevant to the typical NL RN, as most are believed to have limited capacity or tolerance for daily struggles that impact their confidence and esteem (Hodges et al., 2008). Low confidence and uncertainties about practice values (or the practice of other nurses) is most often what drives many new nurses to leave their first jobs and/or the profession altogether (Hodges et al., 2008). Though moral distress was problematic for the participants in this study, they remained consistently committed to the professional values explicated in the ANA Code of Ethics for Nurses (2015) and their objective to become safe, competent, and effective in their practice no matter environmental or interpersonal adversities. They sought to master and survive experiences that stood in opposition to their pursuit and compromised the integrity of their practice. For many new graduate nurses, resilience in TTP is something thought to evolve over time during the first year of practice (Hodges et al, 2008). However, for the participants in this study, it was embodied throughout their individual life courses and refined in their pre-licensure TTP experiences. As such, for the NL RNs in this study, it was present upon initial TTP post-licensure.

Meanings of a “good” nurse.

This study revealed that to be a good nurse (or nursing student) means to be *abled* with respect to the needs or the culture of one’s clinical setting. Participants’

stories highlighted a belief that exists among nurse educators, managers, and practicing nurses; that is, ability means getting the work done efficiently; and, if unable to do this, one is unsuitable for the profession (Evans, 2013). As highlighted via the findings of this study, the embedded beliefs held within academic and clinical learning today are limiting, exclusionary, and privilege getting the work done via a prescriptive path and pace over one's moral character and agency to enact ethical practice. Nursing is inherently a moral endeavor and it is suggested that character determines conduct (Smith & Godfrey, 2002). "The notion of doing good, being good, and acting on the good can be effectively situated within the normative practice and standards of the profession of nursing" (Smith & Godfrey, 2002, p. 9) including the ANA Code of Ethics for Nurses (2015) and the ANA Scope and Standards of Professional Nursing Practice (2010). Salient characteristics of a *good* nurse have been categorized as personal traits and attributes (e.g., positive attitude, courageous, honest, responsible, self-controlled, motivated, with high standards and high morals); technical skills and the management of care (e.g., critical thinking, problem-solving, professional, knowledgeable, efficient, and experienced); work environment and co-workers (e.g., team player, dedicated, accountable, flexible, able to delegate, and complete tasks); and caring behaviors (e.g., kind, helping, empathetic, being an advocate, and a good communicator) (Catlett & Lovan, 2011). Nursing students and NL RNs may experience moral distress in TTP when pace of work is privileged over doing good, being good, and acting on the good (Catlett & Lovan, 2011). Moral distress results in failed TTP and the attrition of good nurses or prospective good nurses from the profession. The findings of the study herein highlighted the

prioritization of students and NL RNs practice know-how over moral formation or character appraisal (Benner, Sutphen, Leonard-Kahn, & Day, 2008).

The participants in this study acknowledged histories of failure and/or their potential for future fallibility. Awareness of their humanness in this regard motivated participants to adhere to certain ideals and ethical principles in carrying out their practice. A virtuous stance also led participants to act reliably and make every attempt to get things right in the practice setting (Newham, 2014), even in the face of skeptical onlookers and workplace adversities. In doing so, all participants reflected the formation of an everyday ethical comportment (Benner et al., 2008). Here, everyday good and ethical practice is thought to resemble meeting the patient as a person and being present; preserving the dignity and personhood of patients; responding to substandard practice, including acts of incivility; and advocating for patients who need support (Benner et al., 2008). The participants in this study shared their stories of implementing good practice and/or advocating for it. Despite their actions, however, rarely were any of the participants in this study acknowledged for them. More often than not, they were misunderstood and in some cases even ridiculed for acts of good will intended to promote safe practice and the best possible outcomes for their patients. The findings of this study present a challenge to nursing faculty, preceptors, and managers to deconstruct their beliefs and assumptions about what it means to be a good nurse. Rather than problematizing difference, it is prudent at this juncture to consider what we can learn from it and how it may be beneficial to the profession and the patients we serve.

Implications

Education.

It is important that those who interface with individuals with learning disabilities are sensitized to their experience and understand the difference between impairment and the social construct of disability (Marks, 2007). For nursing this will no doubt be a challenge given that the medical model undergirds healthcare practice and is the dominant lens through which disability is taught in health professions programs. Participants in this study wanted disability to be a non-issue in nursing education and practice. They wanted to be viewed as unique individuals with a host of abilities. Some thought faculty ought to incorporate conversations about diversity in learning at the start of every new class and convey to classrooms that all individuals have preferred learning styles and methods. Participants wanted to be invited to talk with faculty about their learning goals, struggles, and support needs. Often, the students and NL RNs in this study were the ones to facilitate such conversations and in doing so intermittently experienced marginalization, discrimination, and bias as the result of their labels and requests for alternate learning spaces. No participants disclosed their LD in the practice arena to their preceptors or workplace supervisors, mostly due to fear of job loss or reprisal. Education around disability law and disclosure processes, particularly as relevant to the workplace, may benefit students and new nurses with LD. As well, education may be helpful in fostering disability awareness, legalities, and the competence of nurse educators, preceptors, managers, and staff developers in working with diverse learners, including those with LD. There are a plethora of widely available books and articles

that offer instruction on how to create inclusive classrooms and learning spaces. The stories presented in Chapter 4 may also be of use in facilitating conversations about learning disability with educators, preceptors, managers, and staff developers.

To promote the inclusivity of diverse learners in nursing education and practice, it is paramount that educators, preceptors, managers, and staff developers have the knowledge and expertise to employ concepts related to diversity in teaching/learning, assessment, and creation of inclusive learning spaces, as well as best practices in providing meaningful and balanced feedback to all individual learners. Feedback ought to inspire critical self-reflection and professional growth rather than the disintegration of esteem, confidence, and personal spirit. Research is needed to assess the knowledge and/or gaps in knowledge of educators, preceptors, managers, and staff developers relevant to these areas of focus.

Given the amount of bias, discrimination, and mistreatment experienced by the participants in this study from student nurse peers, faculty, and practicing nurses, it is clear that we need to better understand how disability is being taught in nursing school and specifically if disability theory content exists within today's nursing curricula. In my experience as both a nursing student and nursing faculty member, I have observed disability to be taught via the perspective of the medical or rehabilitative model where disability is conceptualized as something that can be fixed, something that nurses ought to attend to, and that which they should persuade those who are ailing to overcome via treatment. My observation is consistent with research findings about the integration, or lack thereof, disability content within nursing curricula (Smeltzer, Dolan, Robinson-Smith, & Zimmerman, 2005; Cervantez

Thompson, Emrich, & Moore 2003). It is odd that disability is predominantly conceptualized as a medical problem in nursing given that the profession has historically claimed there are multiple ways of knowing experience (Carper, 1978). Notwithstanding, nursing faculty have an obligation to consider other perspectives on disability beyond the medical model and to critically reflect upon their personal ideologies and how they are or are not bringing diverse perspectives about disability into the classroom (Cervantez Thompson et al., 2003; Smeltzer et al., 2005). Broadening our profession's understanding and cultural competence relevant to disability experience promotes humility in care interactions and reduces bias that is generally the result of misperception or an unwillingness to explore things beyond our own experience (Marks, 2007). The demonstration of cultural competence by health professionals will also promote the likelihood of partnerships with healthcare consumers that are lacking now due to ideological differences and negative perceptions of disability.

Most participants in this study came to nursing to explore their interests in various areas of practice. However, students had considerably less exposure to the role of nurses outside of the hospital setting as compared to time spent in acute care environments. The senior nursing students and NL RNs in this study held a strong belief that they needed to start their careers in the hospital setting and acquire at least two years of acute care experience before moving on to other opportunities. Although it is unclear how this belief was informed, it is evident that the students and NL RNs in this study had very limited knowledge of the role of the nurse outside of the hospital setting and the multiple and diverse opportunities that exist within the

profession. The NL RNs in this study took first jobs in acute care settings and all of them later concluded for various reasons (e.g., moral distress, person-environment misfit) that it may not have been the best decision for them. As such, nursing ought to offer formalized career coaching to educate prospective nurses on present day workforce trends, nursing vacancies, and pathways to diverse job opportunities post-licensure. This is essential given current shifts in health care delivery models and the reimagining of the role of the nurse to include more often now the coordination of patient care in communities, clinics, and homes (Institute of Medicine, 2011). Hence, it is possible that a skilled nursing career coach could offer prospective nurses more objective advice and in-depth information about a variety of nursing roles and the success factors relevant to being a *good* nurse in settings beyond hospital-based care areas and clinical practice in general.

Policy.

There is a national effort to increase nursing workforce diversity (LaVeist & Pierre, 2014); however, those with non-evident and/or physical disabilities have yet to be included with regard to this initiative (AACN, 2014). We need to expand our current thinking on diversity in nursing education and practice to include those with disabilities. A diverse nursing workforce is desirable to reflect the population it serves. Almost 20% of the U.S. population self-identifies as having a disability (U.S. Census Bureau, 2012), yet there remains an underrepresentation of healthcare professionals who similarly self-identify. This is no surprise considering the medical lens through which disability is most commonly constructed within the healthcare

arena, nursing's preference for those with a do-ability, and a singular and exclusive path to the profession.

Expanding current initiatives to include those with disability within the future nursing workforce will require political action and a paradigmatic shift at the national level so that paths to nursing beyond those of our tradition can be imagined and implemented (Neal-Boylan & Guillet, 2008). Given current shortages and the future promise of expanded shortages, we need to rethink inclusivity and consider fundamental changes in nursing education and perhaps the tailoring of clinical experiences that foster professional role development in new and diverse settings like education, administration, quality management, and care coordination (Neal-Boylan & Guillet, 2008). Though such efforts might require policy change at the national or state level, nonetheless, we can get started on this work at the local level. Schools of nursing can begin by evaluating their admission processes and clinical placement sites and consider who may be disadvantaged by the nature of current practices or placement conditions. For example, participants in this study illuminated abilities specific to a *good* nurse that thus far OHSU has certainly overlooked in admissions processes, and that in fact may be more relevant to the profession. These participants brought to nursing education and their new roles abilities including survival skills (courage and resilience), self-determination, responsiveness and flexibility in the face of change, creativity and out-of-the-box thinking in problem solving, advocacy skills, relational authenticity, critical self-reflection, risk-taking with a willingness to accept vulnerability, an attitude of inclusivity and acceptance of all individuals, and a genuine empathy for those disabled by societal ideologies and prescribed otherness.

Where admission procedures privilege GPA over other essential abilities it is unlikely that schools of nursing will attract a significant pool of future nurses with diverse backgrounds, experiences, and perspectives that mirror the populations nurses serve.

Culture.

Schools can also begin to look at how inclusivity (or not) is conveyed to prospective nursing students. The general composition of the school's faculty is an indicator of its culture of inclusion or exclusion. The representativeness of faculty with LD is important as prospective nurses with disabilities need role models who they can identify with and who they might observe to have a positive impact within the profession (AACN, 2014). Yet again, there are cultural shifts the academy will need to make to achieve representative numbers of faculty with LD and specifically those willing to disclose within an undercurrent of academic elitism (Denny & Earle, 2005). Participants within this study acknowledged various mentors or role models they encountered throughout their life histories. Many participants came to nursing because of interactions with nursing role models. Just one study participant, however, revealed an encounter with a faculty member who self-disclosed her own learning disability. For this participant it was a relief to learn via this faculty member that individuals with LD can be productive and contribute to the profession in positive ways. It is my assumption based upon my own observations in both academia and practice and via a cursory review of the literature that there are limited numbers of faculty and practicing nurses with disabilities who stand as role models for prospective nurses with LD or other disabilities. More research is needed to understand this observation, as well as on the experiences of nurses and nurse

educators with LD in the workplace, and their involvement in mentoring prospective nurses or new nurses with disabilities.

Academic and workplace incivility in nursing is a pervasive phenomenon and well documented within the literature (Clark, 2008; Gallo, 2012; Luparell, 2011). The normative nature of it across education and practice settings is disturbing (Clark, 2008). Participants' in this study first encountered uncivil behaviors directed toward them by their nursing faculty. This means that some faculty are role-modeling behaviors that perpetuate a culture of hostility, not only in the academic setting, but there is carry-over effect to the clinical workplace. Behavior is most often learned. Thus faculty who behave uncivilly are teaching those in their midst that such acts are acceptable. Despite exposure to negative attacks by faculty, the participants in this study remained professional and on many occasions addressed their attacker, challenging the status quo via their voice (Clark, 2008). However, without needed courage, some students may respond differently. Some may leave nursing altogether while others may conform per faculty expectations (Clark, 2008). As such, if we are to continue to ensure adequate numbers of nurses within the workforce, it may be time for a review of nursing's core values and ethical mandates (ANA, 2015). A zero-tolerance policy specific to incivility is needed (Gallo, 2012) in both academic and practice arenas. There also needs to be a consistent approach for the enforcement of such policy. Though we know much about the prevalence and consequences of incivility in nursing, more interventional research is needed to understand how to best address it. Nursing faculty are the stewards of the profession, the ones charged with preserving and promoting the intrinsic values of our occupation. Stewards of nursing

have an ethical obligation and vested interest in the preparation and transformation of our future nursing workforce (Milton, 2014). Those who act in uncivil ways are doing a grave disservice to the future of our profession and ought to be held accountable. Naming incivility, addressing it consistently, and holding assailants accountable for their actions is a first step in creating culture change, healthy environments, and safe learning spaces.

Strengths & Limitations of the Study

A primary strength of this study was the approach to inquiry. Narrative life history is a methodological approach for examining the human condition in all its variability and complexity. Applying a critical orientation to this type of inquiry also made possible the development of emancipatory knowledge (Campbell & Bunting in Polifroni & Welch, 1999). It allowed participants the opportunity to center their voices, to share their experiences in a safe space, and to be heard. Individuals with disabilities, including LD, are often positioned at the margin, hidden or shunned from the social center by a status of otherness. This study extended to them an invitation to share their personal stories with an interested listener.

In third interviews with participants, I shared with them my interpretation, or the themes I uncovered, relevant to their lives and TTP experiences. Based upon participants' reactions to my interpretations, it was clear that the strengths-based language I used to describe their life patterns was something that in fact, they agreed was true to their experience, but rarely had they heard such words from others. In most cases, interactions with participants and our critical reflection of interpretations enhanced or positively transformed the way in which participants' thought about their

identities and abilities. In other words, the knowledge gained through joint meaning-making efforts freed several participants from oppressive histories and society's dominant discourse on ability, positioning them better to evaluate and respond to their current and true situations (Campbell & Bunting in Polifroni & Welch, 1999). As participants became enlightened by new knowledge, they rejected *tainted* identities and took actions that supported their ongoing survival within the battle of becoming. One participant, despite a history of fear about disability-related stigma and discrimination, said that she was moved to undergo learning disability testing because of her participation in this study. Another participant upon reflection of our interpretation of her life felt empowered by her history as revised and stated she was going to advocate once again for her self and well being in TTP. Similarly, through dialogic communication and the discovery of historical personal strengths, a third participant reclaimed her inner soldier and found the courage to continue her pursuit to become a nurse despite multiple roadblocks ahead in her path.

The results of this narrative life history project also enlightened me to the intersectional experiences of those with LD pursuing careers in nursing. The knowledge I developed through the listening and telling of stories with participants helped me to better understand the contextual nature of disability. It also prompted me to re-conceptualize my own experience of disability in education, to claim it, and subsequently to take new actions to better manage it. After 15 years of struggling with performance anxiety, I was also emancipated through this project from certain beliefs I held about myself related to disability. Personal meanings about ability and disability are shaped by dominant belief systems that are bound in time and generally

distorted (Campbell & Bunting in Polifroni & Welch, 1999). In this project, a methodology involving narrative life history and the application of a critical lens fostered a re-theorization of ability-disability as contextual, not simply stagnant and dichotomous in form as history has taught us to believe.

In this study the final sample was small in size; however, it did not prove to be a limitation in achieving data redundancy. Participants were diverse in many ways, but homogeneous with respect to gender, self-report of disability, nursing program of study, and transition trajectories. And, through the collection and analysis of extensive life history data, the collective standpoint of participants with regard to life, disability, and TTP emerged. The manner in which I represented the findings is also a strong point of this study. Humans are storied creatures and nursing is a storied profession. We learn and make sense of experience through the telling, interpretation, and retelling of story (Riessman, 1993). The short stories explicated in chapter 4 are rich representations of participants' experiences, and they are credible and reliable. Both lay readers and naïve readers with roles in nursing education vetted them. Graduate students enrolled in qualitative dissertation seminar and my committee members, all whom were involved with the data throughout analysis, corroborated my retelling of participants' experiences as well.

The findings of this study, however, are limited to description of the experiences of those who came forward to participate in this study. Though recruitment efforts were expansive, there are individuals who likely chose not to inquire about participation in the study or who I did not reach with my study announcement. We also do not know the experiences of those with LD who may have

left their nursing programs and/or the workforce before inception of this study. The final sample is also limited in that it included primarily white women who attended OHSU School of Nursing and who were of an older demographic than what may exist at other universities. The male student/NL RN experience is not represented, nor are the perspectives of those with LD who identify with other racial or ethnic status beyond that captured in this study. The geographical location of the study is also a limitation. There may be more conservative or more liberal perspectives on disability in other schools of nursing or healthcare facilities beyond those found in this study.

The cross-sectional sampling design was also a limitation of this study. Typically, life history work involves getting to know the lives of individuals over an extensive period of time, sometimes years. I initially intended to conduct a longitudinal study following the same students across time and into practice post-licensure; however it was not feasible given that the time required to complete such a project exceeded the prescribed timeframe in which I had to finish my doctoral program. To minimize this limitation, I conducted three lengthy interviews (60-150 minutes) with each participant (with exception of one who dropped out prior to final interview). These multiple, extended, in-depth interviews allowed sufficient time for me to build trust and rapport with participants, explore in-depth their lives, as well as their cumulative TTP experiences in nursing. The time I allowed for relationship-building, storytelling, and collaborative meaning making also lent to the achievement of data redundancy across cases.

My analysis process might also be perceived as a limitation, specifically “ . . . removing the situation from its telling” (Riessman, 1993, p. 52), or in other words,

eliminating my own narrative involvement in the creation of participants' stories via data reduction. It is possible that this analytic process clouded my understandings of how and why participants' told their stories the way they did. However, reduction of the data in this manner was consistent with a critical epistemology. Moreover, I sought to uncover meaning by privileging the perspective of participants and the content of their stories in their ideal representational form, without the interference of the nuances of our interaction (Riessman, 1993). To minimize this potential limitation, I compared and contrasted original transcriptions that included my narrative contributions with subsequent re-transcriptions that excluded them, and carefully considered my influence on participants' storytelling during interpretation of the data.

Findings of this research, despite the limitations, are helpful in understanding the experience of TTP from the perspectives of persons with LD who were located in diverse positions across the trajectory of TTP during the time of this study. Generalization of findings is not the goal in life history research; however, the results of this inquiry have the potential to be transferrable, empowering people toward moral and just action. Nevertheless, it is up to the readers of this work and their interpretation of it to decipher its relevance and transferability within their own lives.

Future Directions

This study is the first in a program of research intended to expand our understanding of disability, TTP, and inclusion in nursing education and practice. Ongoing studies are needed to further investigate the TTP outcomes of those with LD in nursing. A follow-up investigation with the participants of this study could further

inform us of factors that facilitate and/or impede the occupational outcomes of this group beyond TTP experience. Further research is needed to understand the experiences of male students and NL RNs with LD in TTP. As well, it is important to learn more about nurse educators' experiences in working with students and NL RNs with LD. Research on the experiences of individuals in nursing with physical disabilities and mental health disabilities is also needed. Nursing educators and managers may benefit from research on disability disclosure and the implementation of workplace accommodations as well. Lastly, we need further research on the impact of personal resilience and professional resilience on TTP outcomes, including those within the realm of patient safety, satisfaction, and other aspects of quality care.

The findings of the current study indicate that students and NL RNs with LD (and without) may benefit from practical innovations intended to support transition success. For example, we might better serve all students who self-identify as *at-risk* in terms of TTP success through pre-planning and preparatory processes or mechanisms. Mentoring and coaching programs may be specifically helpful for students with LD or for others of minority status entering nursing. Pairing these students with nurse mentors of similar backgrounds may help recruit and retain a more diverse nursing workforce as well. Action research relevant to these innovations may be useful in testing and continuously improving the inclusion and support of diverse learners, including those with LD, in nursing education and practice.

Summary

The findings of this study are supportive of our current knowledge on the experience of nursing students and nurses with learning disabilities. This work

extends our understanding of the factors that support students and NL RNs in their management of TTP when disability is a compounding element of such experience.

The eight participants in this study experienced multiple academic and workplace adversities upon entry to nursing school and/or in their first RN jobs in the acute care setting. Some of their encounters were typical of TTP for most students and new nurses; however, disability identity complicated certain situations and prompted occurrences of misunderstanding, incivility, closeting, and discrimination.

Participants employed courage and resilience, abilities they developed through a lifetime of managing adverse experiences, during varied combats they faced in the battle of becoming. Reframing low points in life as opportunities for learning and personal growth was a key strategy demonstrative of their resilience. Identifying new meanings specific to their life histories and related patterns of response in TTP through their participation in this project enabled participants to hone in on their personal strengths and forge ahead with their mission to become safe, competent, and effective nurses. This work further highlights that our current conceptualization of TTP may be flawed, as it is limited to the post-licensure period only. Findings of this study indicate that the experiences nursing students and new nurses are exposed to in the course of becoming during the pre-licensure period, and in their lives overall, may impact post-licensure experience. Therefore, having the courage to resist the status quo and resilience in enacting one's moral agency in the face of adversity may be key to retaining new nurses beyond the typical post-licensure TTP period.

Notwithstanding, the findings of this research are reflective of specific social-cultural-political contexts and are bound in time. Thus, it is uncertain how the stories

of these participants will continue to evolve and if/when they will find their way to the other side of TTP. As such, the ending of their stories has yet to be determined.

References

- Aaberg, V. (2012). A path to greater inclusivity through understanding implicit attitudes toward disability. *Journal of Nursing Education, 51*(9), 505-510. doi: 10.3928/01484834-20120706-02
- Accardo, P., Haake, C., & Whitman, B. (1989). The learning-disabled medical student. *Journal of Developmental & Behavioral Pediatrics, 10*(5), 253-258.
- American Association of Colleges of Nursing (AACN). (2012). Nursing shortage fact sheet. Retrieved from <http://www.aacn.nche.edu/mediarelations/NrsgShortageFS.pdf>
- American Association of Colleges of Nursing (AACN). (2014). Fact sheet: Enhancing diversity in the nursing workforce. Retrieved from <http://www.aacn.nche.edu/media-relations/diversityFS.pdf>
- American Nurses Association. (2010). *Scope and standards of practice* (2nd ed.). Retrieved from <http://www.nursesbooks.org/Table-of-Contents/Standards/Nursing-Scope-Standards-of-Practice-2nd-Edition.aspx>.
- American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. Retrieved from <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics-For-Nurses.html>
- Americans with Disabilities Act (ADA) Title III Regulations. (2010). *Nondiscrimination on the basis of disability in public accommodations and commercial facilities*. Subpart A, Part 36, Section 36.104. Retrieved from http://www.ada.gov/regs2010/titleIII_2010/titleIII_2010_regulations.htm#a102

Americans with Disabilities Act of 1990, as amended (ADAA). (2008). Public law 110-325. Retrieved from <http://www.ada.gov/pubs/adastatute08.htm>

Anderson, G., Hair, C., & Todero, C. (2012). Nurse residency programs: An evidence-based review of theory, process, and outcomes. *Journal of Professional Nursing, 28*(4), 203–212. doi:10.1016/j.profnurs.2011.11.020.

Atkinson, R. (1998). *The life story interview*. London, UK: Sage Publications.

Bates, B. (1997). Transitions: Issues for the adult learner with learning disabilities. *Linkages, Linking Literacy & Learning Disabilities, 4*(1), 1-21.

Becoming. (n.d.) In Collins English Dictionary online. (2015). Retrieved from <http://www.collinsdictionary.com/dictionary/english/becoming>

Benner, P., Sutphen, M., Leonard-Kahn, V., & Day, L. (2008). Formation and everyday ethical comportment. *American Journal of Critical Care, 17*, 473-476. Retrieved from http://www.researchgate.net/profile/Victoria_Leonard/publication/23241975_Formation_and_everyday_ethical_comportment/links/02e7e5164e437b67f2000000.pdf

Blair, S. (2000). The centrality of occupation during life transitions. *British Journal of Occupational Therapy, 63*(5), 231-237. doi: 10.1177/030802260006300508

Bohne, J. M. (2004). Valuing differences among nursing students. *Journal of Nursing Education, 43*(5), 202-203.

Boychuk Duchscher, J. (2009). Transition shock: The initial stage of role adaptation for newly graduated registered nurses. *Journal of Advanced Nursing, 65*(5), 1103-1113. doi: 10.1111/j.1365-2648.2008.04898.x

- Bradshaw, M. J., & Salzer, J. S. (2003). The nursing student with attention deficit hyperactivity disorder. *Nurse Educator*, 28(4), 161-165.
- Bramwell, L. (1984). Use of the life history in pattern identification and health promotion. *Advances in Nursing Science*, 7(1), 37-44.
- Bridges, W. (2009). *Managing transitions: Making the most of change*. Cambridge, MA: Da Capo Press, Incorporated.
- Brisenden, S. (1986). Independent living and the medical model of disability. *Disability, Handicap, and Society*, 1(2), 173-178. doi: 10.1080/02674648666780171
- Buerhaus, P., Staiger, D., & Auerbach, D. (2009). *The future of the nursing workforce in the United States: Data trends, and implications*. Sudbury, MA: Jones and Bartlett Publishers.
- Buzzanell, P. (2010). Resilience: Talking, resisting, and imagining new normalcies into being. *Journal of Communications*, 60, 1-14. doi: 10.1111/j.1460-2466.2009.01469.x
- Byrd, C. Y., Hood, L., & Youtsey, N. (1997). Student and preceptor perceptions of factors in a successful learning partnership. *Journal of Professional Nursing*, 13(6), 344-351. doi: 10.1016/S8755-7223(97)80080-4
- Campbell, J. (2008). *The hero with a thousand faces* (3rd ed.). Novato, CA: New World Library.
- Campbell, J. C., & Bunting, S. (1999). Voices and paradigms: Perspectives on critical and feminist theory in nursing. In E. C. Polifroni & M. Welch (Eds.), *Perspectives on philosophy of science in nursing: An historical and*

contemporary anthology (411-422). Philadelphia, PA: Lippincott Williams & Wilkins.

Carper, B. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science, 1*(1), 13-23.

Casey, K. (1993). *'I answer with my life': Life histories of women teachers working for social change*. New York: Routledge.

Casey, K., Fink, R., Jaynes, C., Campbell, L., Cook, P., & Wilson, V. (2011).

Readiness for practice: The senior practicum experience. *Journal of Nursing Education, 50*(11), 646-652. doi: 10.3928/01484834-20110817-03

Catlett, S., & Lovan, S.R. (2011). Being a good nurse and doing the right thing: A replication study. *Nursing Ethics, 18*(1), 54-62. doi: 10.1177/0969733010386162

Cervantez Thompson, T. L., Emrich, K., & Moore, G. (2003). The effect of curriculum on the attitudes of nursing students toward disability. *Rehabilitation Nursing, 28*(1), 27-30. doi: 10.1002/j.2048-7940.2003.tb01718.x

Clark, C. (2008). Student voices on faculty incivility in nursing education: A conceptual model. *Nursing Education Perspectives, 29*(5), 284-289.

dx.doi: [http://dx.doi.org/10.1043/1536-5026\(2008\)029\[0284:SVOFII\]2.0.CO;2](http://dx.doi.org/10.1043/1536-5026(2008)029[0284:SVOFII]2.0.CO;2)

Cole, A., & Knowles, J. (Eds.). (2001). *Lives in context: The art of life history research*. New York, NY: Altamira Press.

Collins, P. (1990). Knowledge, consciousness, and the politics of empowerment (2nd ed.). *Black feminist thought: Knowledge, consciousness, empowerment,*

perspectives on gender (pp. 221-238). New York, NY: Routledge.

- Collinson, C., & Penketh, C. (2010). 'Sit in the corner and don't eat the crayons': Postgraduates with dyslexia and the dominant 'lexic' discourse. *Disability & Society*, 25(1), 7-19. doi: 10.1080/09687890903363274
- Colon, E. J. (1997). Identification, accommodation, and success of students with learning disabilities in nursing education programs. *Journal of Nursing Education*, 36(8), 372-377.
- Connor, K.M., & Davidson, J.R.T. (2003). Development of a new resilience scale: The Connor-Davidson resilience scale (CD-RISC). *Depression and Anxiety*, 18, 76-82. doi: 10.1002/da.10113
- Copeland, J., Chan, F., Bezyak, J., & Fraser, R. T. (2010). Assessing cognitive and affective reactions of employers toward people with disabilities in the workplace. *Journal of Occupational Rehabilitation*, 20(4), 427-434. doi: 10.1007/s10926-009-9207-y
- Davis, L. (1997). Constructing normalcy: The bell curve, the novel, and the invention of the disabled body in the nineteenth century. In Davis, L. (Ed.), *The disability studies reader* (pp. 9-28). New York, NY: Routledge.
- Davis, L. (Ed.). (2013). *The disability studies reader* (4th ed.). New York, NY: Routledge.
- Dear, M. R., & Keen, M. F. (1982). Role transition: A practicum for baccalaureate nursing students. *The Journal of Nursing Education*, 21(2), 32-37.
- Denhart, H. (2008). Deconstructing barriers: Perceptions of students labeled with learning disabilities in higher education. *Journal of Learning Disabilities*, 41(6), 483-497. doi: 10.1177/0022219408321151

- Denny, E., & Earle, S. (2005). *Sociology for nurses*. Malden, MA: Polity Press.
- DeReus, L.A., Few, A.L., & Blume, L.B. (2005). Multicultural and critical race feminisms: Theorizing families in the third wave. In Bengtson, V., Acock, A., Dilworth-Anderson, P., & Klein, D. (Eds.), *Sourcebook of family theory & research* (pp. 447-468). Thousand Oaks, CA: Sage.
- Denzin, N. (1989). *Interpretive biography*. London, UK: Sage Publications.
- Denzin, N. (2001). *Interpretive interactionism* (2nd ed.). London, UK: Sage Publications.
- DeWolfe, J. A., Perkin, C. A., Harrison, M. B., Laschinger, S., Oakley, P., Peterson, J., & Seaton, F. (2010). Strategies to prepare and support preceptors and students for preceptorship: A systematic review. *Nurse Educator*, 35(3), 98-100. doi: 10.1097/NNE.0b013e3181d95014
- Dewsbury, G., Clarke, K., Randall, D., Rouncefield, M., & Sommerville, I. (2004). The anti-social model of disability. *Disability and Society*, 19(2), 145-158. doi: 10.1080/0968759042000181776
- Dowrick, P. W., Anderson, J., Heyer, K., & Acosta, J. (2005). Postsecondary education across the USA: Experiences of adults with disabilities. *Journal of Vocational Rehabilitation*, 22(1), 41-47.
- Dudley-Marling, C. (2004). The social construction of learning disabilities. *Journal of Learning Disabilities*, 37(6), 482-489. doi: 10.1177/00222194040370060201
- Dupler, A. E., Allen, C., Maheady, D. C., Fleming, S. E., & Allen, M. (2012). Leveling the playing field for nursing students with disabilities: Implications of

- the amendments to the Americans with Disabilities Act. *Journal of Nursing Education, 51*(3), 140-144. doi: 10.3928/01484834-20120127-05
- Durlak, C. M., Rose, E., & Bursuck, W.D. (1994). Preparing high school students with learning disabilities for the transition to postsecondary education: Teaching the skills of self-determination. *Journal of Learning Disabilities, 27*(1), 51-59. doi: 10.1177/002221949402700108
- Dyess, S. M., & Sherman, R. O. (2009). The first year of practice: New graduate nurses' transition and learning needs. *Journal of Continuing Education in Nursing, 40*(9), 403-410. doi: 10.3928/00220124-20090824-03
- Eliason, M. J. (1992). Nursing students with learning disabilities: Appropriate accommodations. *The Journal of Nursing Education, 31*(8), 375-376.
- Evans, W. (2013). 'I am not a dyslexic person I'm a person with dyslexia': Identity constructions of dyslexia among students in nurse education. *Journal of Advanced Nursing, 70*(2), 360-372. doi: 10.1111/jan.12199
- Ferguson, D. S., Evans, V. S., Hajduk, D. B., Jones, D. L., Liston, D., Myers, E., . . . Zuraikat, N. (2009). Enable the disabled: An untapped resource for the nursing shortage. *Nursing Management, 40*(2), 9-11. doi: 10.1097/01.NUMA.0000345866.84071.b3
- Field, S., Martin, J., Miller, R., Ward, M., & Wehmeyer, M. (1998). *A practical guide to teaching self-determination*. Reston, VA: Council for Exceptional Children.
- Field, S., Sarver, M. D., & Shaw, S. F. (2003). Self-determination: A key to success in postsecondary education for students with learning disabilities. *Remedial & Special Education, 24*(6), 339-349. doi: 10.1177/07419325030240060501

- Fisher, W. (1989). *Human communication as narration: Toward a philosophy of reason, value, and action*. Columbia, SC: University of South Carolina Press.
- Fletcher, D., & Fletcher, J. (2005). A meta-model of stress, emotions and performance: Conceptual foundations, theoretical framework, and research direction. *Journal of Sports Sciences, 23*, 157-158.
- Fletcher, D., & Sarkar, M. (2012). A grounded theory of psychological resilience in olympic champions. *Psychology of Sport and Exercise, 13*, 669-678.
doi:10.1016/j.psychsport.2012.04.007
- Fletcher, D., & Sarkar, M. (2013). Psychological resilience: A review and critique of definitions, concepts, and theory. *European Psychologist, 18*(1), 12-23.
dx.doi: <http://dx.doi.org/10.1027/1016-9040/a000124>
- Freeling, M., & Parker, S. (2015). Exploring experienced nurses' attitudes, views and expectations of new graduate nurses: A critical review. *Nurse Education Today, 35*(2), 42-49. doi:10.1016/j.nedt.2014.11.011
- Gallo, V.J. (2012). Incivility in nursing education: A review of the literature. *Teaching and Learning in Nursing, 7*, 63-66. doi:10.1016/j.teln.2011.11.006
- Gartland, D., & Strosnider, R. (2007). The documentation disconnect for students with learning disabilities: Improving access to postsecondary disability services. (2007). *Learning Disability Quarterly, 30*(4), 265-274.
- Gerber, P. (2009). Transition and adults with learning disabilities. In J. M. Taymans, H. L. Swanson, R. L. Schwarz, N. Gregg, M. Hock & P. Gerber (Eds.), *Learning to achieve: A review of the research literature on serving adults with learning disabilities* (pp. 211-227). Washington, D.C.: National Institute for Literacy.

- Gerber, P. J., Ginsberg, R., & Reiff, H. B. (1992). Identifying alterable patterns in employment success for highly successful adults with learning disabilities. *Journal of Learning Disabilities, 25*(8), 475-487.
doi: 10.1177/002221949202500802
- Gerber, P. J., Price, L. A., Mulligan, R., & Shessel, I. (2004). Beyond transition: A comparison of the employment experiences of American and Canadian adults with LD. *Journal of Learning Disabilities, 37*(4), 283-291. doi: 10.1177/00222194040370040101
- Goodley, D. (2001). 'Learning difficulties', the social model of disability and impairment: Challenging epistemologies. *Disability and Society, 16*(2), 207-231.
doi: 10.1080/09687590120035816
- Goodley, D. (2005). Empowerment, self-advocacy and resilience. *Journal of Intellectual Disabilities, 9*(4), 333-343. doi: 10.1177/1744629505059267
- Goodley, D. (2011). *Disability studies: An interdisciplinary introduction*. SAGE Publications: London, U.K.
- Grealish, L., & Trevitt, C. (2005). Developing a professional identity: Student nurses in the workplace. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 19*(1-2), 137-150. doi: 10.5172/conu.19.1-2.137
- Green, S., Davis, C., Karshmer, E., Marsh, P., & Straight, B. (2005). Living stigma: The impact of labeling, stereotyping, separation, status loss, and discrimination in the lives of individuals with disabilities and their families. *Sociological Inquiry, 75*(2), 197-215. doi: 10.1111/j.1475-682X.2005.00119.x

- Gregg, N. (2007). Underserved and unprepared: Postsecondary learning disabilities. *Learning Disabilities Research & Practice, 22*(4), 219-228. doi: 10.1111/j.1540-5826.2007.00250.x
- Griffiths, L., Worth, P., Scullard, Z., & Gilbert, D. (2010). Supporting disabled students in practice: A tripartite approach. *Nurse Education in Practice, 10*(3), 132-137. doi: 10.1016/j.nepr.2009.05.001
- Guillemin, M., & Gillam, L. (2004). Ethics, reflexivity, and "ethically important moments" in research. *Qualitative Inquiry, 10*(2), 261-280. doi: 10.1177/1077800403262360
- Gutkind, L. (2012). *You can't make this stuff up: The complete guide to writing creative nonfiction – from memoir to literary journalism and everything in between*. Boston, MA: Da Capo Press.
- Harwood, M. (2011). *Transition shock - hitting the ground running*. Tasmania, QLD: School of Nursing & Midwifery, University of Tasmania.
- Helms, L., Jorgensen, J., & Anderson, M. A. (2006). Disability law and nursing education: An update. *Journal of Professional Nursing, 22*(3), 190-196. doi: 10.1016/j.profnurs.2006.03.005
- Hodges, H., Keely, A., & Troyan, P. (2008). Professional resilience in baccalaureate-prepared acute care nurses: First steps. *Nursing Education Perspectives, 29*(2), 80-89. dx.doi: [http://dx.doi.org/10.1043/1094-2831\(2008\)29\[80:PRIBAC\]2.0.CO;2](http://dx.doi.org/10.1043/1094-2831(2008)29[80:PRIBAC]2.0.CO;2)

- Hofler, L. D. (2008). Nursing education and transition to the work environment: A synthesis of national reports. *Journal of Nursing Education, 47*(1), 5-12. doi: 10.3928/01484834-20080101-06
- Holloway, I., & Freshwater, D. (2007). *Narrative research in nursing*. Malden, MA: Blackwell Publishing.
- Hussey, T., & Smith, P. (2010). Transitions in higher education. *Innovations in Education and Teaching International, 47*(2), 155-164. doi: 10.1080/14703291003718893
- Ijiri, L., & Kudzma, E. C. (2000). Supporting nursing students with learning disabilities: A metacognitive approach. *Journal of Professional Nursing, 16*(3), 149-157. doi: 10.1053/PN.2000.5917
- Illingworth, K. (2005). The effects of dyslexia on the work of nurses and healthcare assistants. *Nursing Standard, 19*(38), 41-48. dx.doi: <http://dx.doi.org/10.7748/ns2005.06.19.38.41.c3880>
- Individuals with Disabilities Education Act (IDEA). (2004). Public Law 108-446. Retrieved from <http://idea.ed.gov/download/statute.html>
- Ingstad, B., & Whyte, S. (Eds.). (2007). *Disability in local and global worlds*. Berkeley, CA: University of California Press.
- Institute of Medicine (IOM). (2010). A summary of the February 2010 forum on the future of nursing: Education. Retrieved from http://www.nap.edu/openbook.php?record_id=12894
- Institute of Medicine (IOM). (2011). *Future of nursing report: Leading change, advancing health*. Retrieved from

http://www.thefutureofnursing.org/sites/default/files/Future%20of%20Nursing%20Report_0.pdf

International Dyslexia Association. (2015). Definition of dyslexia. Retrieved from

<http://eida.org/definition-of-dyslexia/>

Israelite, N., Swartz, K., Huynh, J., & Tocco, A. (2005). Post-secondary students and graduates with disabilities: The transition from university to work. *Exceptionality Education Canada, 15*(2), 5-26.

Jackson, D., Firtko, A., & Edenborough, M. (2007). Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: A literature review. *Journal of Advanced Nursing, 60*(1), 1-9. doi: 10.1111/j.1365-2648.2007.04412.x

Janiga, S. J., & Costenbader, V. (2002). The transition from high school to postsecondary education for students with learning disabilities: A survey of college service coordinators. *Journal of Learning Disabilities, 35*(5), 462. doi: 10.1177/00222194020350050601

Kant, I., & Pluhar, W. S. (1987). *Critique of judgment*. Indianapolis, IN: Hackett Publishing Company, Inc.

Kennedy, J. M., Nichols, A. A., Halamek, L. P., & Arafah, J. M. R. (2012). Nursing department orientation: Are we missing the mark? *Journal for Nurses in Staff Development, 28*(1), 24-26. doi: 10.1097/NND.0b013e318240a6f3

Kim, K. H. (2003). Baccalaureate nursing students' experiences of anxiety producing situations in the clinical setting. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 14*(2), 145-155. doi: 10.5172/conu.14.2.145

- Kim, K. H. (2007). Clinical competence among senior nursing students after their preceptorship experiences. *Journal of Professional Nursing, 23*(6), 369-375. doi: 10.1016/j.profnurs.2007.01.019
- King, P. (1989). A woman of the land. *Image: Journal of Nursing Scholarship, 21*(1), 19-22. doi: 10.1111/j.1547-5069.1989.tb00092.x
- Knowles, J.G. (1994). Metaphors as windows on a personal history: A beginning teacher's experience. *Teacher Education Quarterly, 21*(1), 37-66.
- Kolanko, K. M. (2003). A collective case study of nursing students with learning disabilities. *Nursing Education Perspectives, 24*(5), 251-256. dx.doi: [http://dx.doi.org/10.1043/1536-5026\(2003\)024<0251:ACCSO>2.0.CO;2](http://dx.doi.org/10.1043/1536-5026(2003)024<0251:ACCSO>2.0.CO;2)
- Koller, J. R. (1994). Improving transition outcomes for persons with specific learning disabilities. *American Rehabilitation, 20*(2), 37.
- Koontz, A. M., Mallory, J. L., Burns, J. A., & Chapman, S. (2010). Staff nurses and students: The good, the bad, and the ugly. *MEDSURG Nursing, 19*(4), 240-245.
- Laschinger, H.K., & MacMaster, E. (1992). Effect of pregraduate preceptorship experience on development of adaptive competencies of baccalaureate nursing students. *Journal of Nursing Education, 31*(6), 258-264.
- LaVeist, T. & Pierre, G. (2014). Integrating the 3Ds – Social determinants, health disparities, and health-care workforce diversity. *Public Health Reports, 129*(2), 9-14. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863706/>
- Learning Disabilities Association of America (LDA). (2004). Types of learning disabilities. Retrieved from http://www.ldanatl.org/aboutld/parents/ld_basics/types.asp

- Letizia, M. (1995). Issues in the postsecondary education of learning-disabled nursing students. *Nurse Educator, 20*(5), 18-22.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. London, UK: Sage Publications.
- Lombardi, A. R., & Murray, C. (2011). Measuring university faculty attitudes toward disability: Willingness to accommodate and adopt universal design principles. *Journal of Vocational Rehabilitation, 34*(1), 43-56. doi: 10.3233/JVR-2010-0533
- Luparell, S. (2011). Incivility in nursing: The connection between academia and clinical settings. *Critical Care Nurse, 31*(2), 92-95. doi: 10.4037/ccn2011171
- Luthar, S.S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: Implications for interventions and social policies. *Development and Psychopathology, 12*, 857-885.
- Madaus, J. W. (2005). Navigating the college transition maze: A guide for students with learning disabilities. *Teaching Exceptional Children, 37*(3), 32-37.
- Retrieved from
<http://w.oaklandcatholic.org/media/7689/navigatingcollegetransitionmaze.pdf>
- Madaus, J. W., & Shaw, S. F. (2006). The impact of the IDEA 2004 on transition to college for students with learning disabilities. *Learning Disabilities Research & Practice (Blackwell Publishing Limited), 21*(4), 273-281. doi: 10.1111/j.1540-5826.2006.00223.x
- Madaus, J. W., Gerber, P. J., & Price, L. A. (2008a). Adults with learning disabilities in the workforce: Lessons for secondary transition programs. *Learning Disabilities Research & Practice (Blackwell Publishing Limited), 23*(3), 148-153. doi: 10.1111/j.1540-5826.2008.00272.x

- Madaus, J. W., Zhao, J., & Ruban, L. (2008b). Employment satisfaction of university graduates with learning disabilities. *Remedial & Special Education, 29*(6), 323-332. doi: 10.1177/0741932507312012
- Magilvy, J. K., & Mitchell, A. C. (1995). Education of nursing students with special needs. *The Journal of Nursing Education, 34*(1), 31-36.
- Maheady, D. C. (1999). Jumping through hoops and walking on eggshells: The experiences of nursing students with disabilities. *Journal of Nursing Education, 38*(4), 162-170.
- Marcum, E. H., & West, R. D. (2004). Structured orientation for new graduates: A retention strategy. *Journal for Nurses in Staff Development, 20*(3), 118-124.
- Marks, B. (2007). Cultural competence revisited: Nursing student with disabilities. *Journal of Nursing Education, 46*(2), 70-74. Retrieved from <http://senate.ucsf.edu/2006-2007/son-04-20-07-agenda-at6.pdf>
- Martin, D., Nelda, G., Walker, M. (2015). The baccalaureate big 5: What magnet hospitals should expect from a baccalaureate generalist nurse. *Journal of Nursing Administration, 45*(3), 121-123. doi: 10.1097/NNA.0000000000000168
- Matt, S. (2011). Nurses with disabilities: A pilot test of the nurses' attitudes toward nurses with disabilities scale. *Journal of Research in Nursing, 17*(4), 376-392. doi: 10.1177/1744987111406523
- May, A.L., & Stone, C.A. (2010). Stereotypes of individuals with learning disabilities: Views of college students with and without learning disabilities. *Journal of Learning Disabilities, 43*(6), 483-489. doi: 10.1177/0022219409355483

- May, K. A. (2014). Nursing faculty knowledge of the Americans with Disabilities Act. *Nurse Educator, 39*(5), 241-245. doi: 10.1097/NNE.0000000000000058
- McCleary-Jones, V. (2008). Strategies to facilitate learning among nursing students with learning disabilities. *Nurse Educator, 33*(3), 105-106. doi: 10.1097/01.NNE.0000312187.28519.48
- McQueen, A. (2004). Emotional intelligence in nursing work. *Journal of Advanced Nursing, 47*(1), 1010-108. doi: 10.1111/j.1365-2648.2004.03069.x
- Meichenbaum, D. (1985). *Stress inoculation training*. New York, NY: Pergamon.
- Meleis, A. I. (Ed.). (2010). *Transitions theory*. New York, NY: Springer Publishing Company.
- Mellard, D. (2005). Strategies for transition to postsecondary educational settings. *Focus on Exceptional Children, 37*(9), 1-19. Retrieved from <https://kuscholarworks.ku.edu/bitstream/handle/1808/4206/Strategies%20for%20Transition%20to%20Postsecondary%20Educational%20Settings.pdf?sequence=1&isAllowed=y>
- Mellard, D. F., & Hazel, J.S. (1992). Social competencies as a pathway to successful life transition. *Learning Disabilities Quarterly, 15*, 251-273. doi: 10.2307/1511317
- Meloy, F., & Gambescia, S. (2014). Guidelines for response to student requests for academic considerations: Support verses enabling. *Nurse Educator, 39*(3), 138-142). doi: 10.1097/NNE.0000000000000037

- Milsom, A., & Hartley, M. T. (2005). Assisting students with learning disabilities transitioning to college: What school counselors should know. *Professional School Counseling, 8*(5), 436-441.
- Milton, C. (2014). Stewardship and leadership in nursing. *Nursing Science Quarterly, 27*(2), 108-110. doi: 10.1177/0894318414522661
- Mood, L. (2009). Situated nursing practice. Paper presented at OHSU, Dec. 1, Portland, OR.
- Moran, R. (2012). Retention of new graduate nurses: The literature informs staff educators. *Journal for Nurses in Staff Development, 28*(6), 270-273. doi: 10.1097/NND.0b013e318272584a
- Morris, D. K., & Turnbull, P. A. (2007). The disclosure of dyslexia in clinical practice: Experiences of student nurses in the United Kingdom. *Nurse Education Today, 27*(1), 35-42. doi: 10.1016/j.nedt.2006.01.017
- Morris, D.K., & Turnbull, P.A. (2006). Clinical experiences of students with dyslexia. *Journal of Advanced Nursing, 54*(2), 238-247. doi: 10.1111/j.1365-2648.2006.03806.x
- Myers, S., Reidy, P., French, B., McHale, J., Chisholm, M., & Griffin, M. (2010). Safety concerns of hospital-based new-to-practice registered nurses and their preceptors. *Journal of Continuing Education in Nursing, 41*(4), 163-171. doi: 10.3928/00220124-20100326-02
- Myrick, F. (2002). Preceptorship and critical thinking in nursing education. *The Journal of Nursing Education, 41*(4), 154-164.

- National Council of State Boards of Nursing (NCSBN). (2015). Transition to practice. Retrieved from <https://www.ncsbn.org/transition-to-practice.htm>.
- National Joint Committee on Learning Disabilities (NJCLD). (2007). The documentation disconnect for students with learning disabilities: Improving access to postsecondary disability services. Retrieved from https://www.ahead.org/uploads/docs/resources/njld_paper.pdf
- National League for Nursing (NLN). (2011). A commitment to diversity in nursing education. Retrieved from http://www.nln.org/aboutnln/reflection_dialogue/refl_dial_3.htm
- Neal-Boylan, L. & Guillet, S. (2008). Nurses with disabilities: Can changing our educational system keep them in nursing? *Nurse Educator*, 33(4), 164-167. doi: 10.1097/01.NNE.0000312194.89438.62
- Newham, R. (2014). Virtue ethics and nursing: On what grounds? *Nursing Philosophy*, 16, 40-50. doi: 10.1111/nup.12063
- Oliver, M. (1996). *Understanding disability: From theory to practice*. New York, NY: St. Martin's Press.
- Park, M., & Jones, C. B. (2010). A retention strategy for newly graduated nurses: An integrative review of orientation programs. *Journal for Nurses in Staff Development*, 26(4), 142-151. doi: 10.1097/NND.0b013e31819aa130
- Parker, D., & Lawton, R. (2003). Psychological contribution to the understanding of adverse events in health care. *Quality and Safety in Health Care*, 12, 453-457. doi: 10.1136/qhc.12.6.453

- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). London, UK: Sage Publications.
- Price, G., & Gale, A. (2006). How do dyslexic nursing students cope with clinical practice placements? The impact of the dyslexic profile on the clinical practice of dyslexic nursing students: Pedagogical issues and considerations. *Learning Disabilities: A Contemporary Journal*, 4(1), 19-36.
- Price, L. A., Gerber, P. J., & Mulligan, R. (2007). Adults with learning disabilities and the underutilization of the americans with disabilities act. *Remedial and Special Education*, 28(6), 340-344. doi: 10.1177/07419325070280060301
- Ralph, E., Walker, K., & Wimmer, R. (2009). Practicum and clinical experiences: Postpracticum students' views. *Journal of Nursing Education*, 48(8), 434-440. doi: 10.3928/01484834-20090518-02
- Read, C.Y., Vessey, J.A., Amar, A.F., & Cullinan, D.M. (2013). The challenges of inclusivity in baccalaureate nursing programs. *Journal of Nursing Education*, 52(4), 185-190. Retrieved from http://www.researchgate.net/profile/Angela_Amar/publication/235690126_The_Challenges_of_Inclusivity_in_Baccalaureate_Nursing_Programs/links/00b7d53c5df24295b3000000.pdf
- Rebeschi, L., & Aronson, B. (2009). Assessment of nursing student's learning outcomes and employment choice after the implementation of a senior capstone course. *International Journal of Nursing Education Scholarship*, 6(1) doi: 10.2202/1548-923X.1775

- Richardson, G.E. (2002). The metatheory of resilience and resiliency. *Journal of Clinical Psychology, 58*, 307-321. doi: 10.1002/jclp.10020
- Ridley, C. (2011). The experiences of nursing students with dyslexia. *Nursing Standard, 25*(24), 35-42. dx.doi:
<http://dx.doi.org/10.7748/ns2011.02.25.24.35.c8342>
- Riessman, C. (1993). *Narrative analysis*. London, UK: Sage Publications.
- Rojewski. (1999). Occupational and educational aspirations and attainment of young adults with and without LD. *Journal of Learning Disabilities, 32*(6), 533. doi: 10.1177/002221949903200606
- Romyn, D. M., Linton, N., Giblin, C., Hendrickson, B., Limacher, L. H., Murray, C., . . . Zimmel, C. M. (2009). Successful transition of the new graduate nurse. *International Journal of Nursing Education Scholarship, 6*(1), 17p. doi: 10.2202/1548-923X.1802
- Rosebraugh, C. J. (2000). Learning disabilities and medical schools. *Medical Education, 34*(12), 994-1000. doi: 10.1111/j.1365-2923.2000.00689.x
- Saldana, J. (2013). *The coding manual for qualitative researchers* (2nd ed.). London, UK: SAGE Publications.
- Sandelowski, M. (1991). Telling stories: Narrative approaches to qualitative research. *IMAGE: Journal of Nursing Scholarship, 23*(3), 161-166. doi: 10.1111/j.1547-5069.1991.tb00662.x
- Sanderson-Mann, J., & McCandless, F. (2006). Understanding dyslexia and nurse education in the clinical setting. *Nurse Education in Practice, 6*(3), 127-133. doi: 10.1016/j.nepr.2005.10.004

- Schoessler, M., & Waldo, M. (2006a). Organizational infrastructure to support development of newly graduated nurses. *Journal for Nurses in Staff Development, 22*(6), 286-295.
- Schoessler, M., & Waldo, M. (2006b). The first 18 months in practice: A developmental transition model for the newly graduated nurse. *Journal for Nurses in Staff Development, 22*(2), 47-52. doi: 10.1097/00124645-200603000-00001
- Selekman, J. (2002). Nursing students with learning disabilities. *The Journal of Nursing Education, 41*(8), 334-339.
- Shakespeare, T. (2006). *Disability rights and wrongs*. New York, NY: Routledge.
- Shellenbarger, T. (1993). Helping the dyslexic nursing student. *Nurse Educator, 18*(6), 10-13.
- Siebers, T. (2011). *Disability theory*. Ann Arbor, MI: University of Michigan Press.
- Siperstein, G. N. (1988). Students with learning disabilities in college: The need for a programmatic approach to critical transitions. *Journal of Learning Disabilities, 21*(7). doi: 10.1177/002221948802100708
- Sitlington, P. L. (2003). Postsecondary education: The other transition. *Exceptionality, 11*(2), 103.
- Sitlington, P. L., & Payne, E. M. (2004). Information needed by postsecondary education: Can we provide it as part of the transition assessment process? *Learning Disabilities -- A Contemporary Journal, 2*(2), 1-14. doi: 10.1207/S15327035EX1102_05

- Skinner, M. E., & Lindstrom, B. D. (2003). Bridging the gap between high school and college: Strategies for the successful transition of students with learning disabilities. *Preventing School Failure, 47*(3), 132. doi: 10.1080/10459880309604441
- Smeltzer, S., Dolen, M.A., Robinson-Smith, G., & Zimmerman, V. (2005). Integration of disability-related content in nursing curricula. *Nursing Education Perspectives, 26*(4), 210-216. dx.doi: [http://dx.doi.org/10.1043/1094-2831\(2005\)026\[0210:IODCIN\]2.0.CO;2](http://dx.doi.org/10.1043/1094-2831(2005)026[0210:IODCIN]2.0.CO;2)
- Smith, J. (2004). Transitions from student to practicing nurse. *JONA's Healthcare Law, Ethics & Regulation, 6*(3), 77-78.
- Smith, K.V., & Godfrey, N. (2002). Being a good nurse and doing the right thing: A qualitative study. *Nursing Ethics, 9*(3), 301-312. doi: 10.1191/0969733002ne512oa
- Society for Disability Studies (SDS). (2012). SDS fall 2012 newsletter. Retrieved from <http://disstudies.org/about/newsletters/fall-2012-newsletter/>
- Sowers, J. A., & Smith, M. R. (2004). Nursing faculty members' perceptions, knowledge, and concerns about students with disabilities. *The Journal of Nursing Education, 43*(5), 213-218.
- Spector, N., Blegen, M.A., Silvestre, J., Barnsteiner, J., Lynn, M.R., Ulrich, B., Fogg, L., Alexander, M. (2015). Transition to practice study in hospital settings. *Journal of Nursing Regulation, 5*(4), 24-38. Retrieved from https://www.ncsbn.org/Spector_Transition_to_Practice_Study_in_Hospital_Settings.pdf

- Tervo, R.C., Palmer, G., & Redinius, P. (2004). Health professional student attitudes towards people with disability. *Clinical Rehabilitation, 18*, 908-915. doi: 10.1191/0269215504cr820oa
- Theisen, J. L., & Sandau, K. E. (2013). Competency of new graduate nurses: A review of their weaknesses and strategies for success. *Journal of Continuing Education in Nursing, 44*(9), 406–414. doi: 10.3928/00220124-20130617-38
- Thrysoe, L., Hounsgaard, L., Dohn, N.B., & Wagner, L. (2011). Expectations of becoming a nurse and experiences on being a nurse. *Nursing Science, 31*(3), 15-19.
- Trainor, A. A. (2005). Self-determination perceptions and behaviors of diverse students with LD during the transition planning process. *Journal of Learning Disabilities, 38*(3), 233-249. doi: 10.1177/00222194050380030501
- Trainor, A. A. (2007). Perceptions of adolescent girls with LD regarding self-determination and postsecondary transition planning. *Learning Disability Quarterly, 30*(1), 31-45. doi: 10.2307/30035514
- Tugade, M.M., & Fredrickson, B.L. (2004). Resilient individuals use positive emotions to bounce back from negative emotional experiences. *J Pers Soc Psychol, 86*(2) 320-333.
- Tumminia, P. A., & Weinfield, A. M. (1983). Teaching the learning-disabled nursing student. *Nurse Educator, 8*(4), 12-14.
- Udlis, K. A. (2008). Preceptorship in undergraduate nursing education: An integrative review. *Journal of Nursing Education, 47*(1), 20-29. doi: 10.3928/01484834-20080101-09

- U.S. Census Bureau. (2012). Newsroom archive: Nearly 1 in 5 people have a disability in the U.S. Retrieved from <https://www.census.gov/newsroom/releases/archives/miscellaneous/cb12-134.html>
- U.S. Department of Education. (2006). Identification of specific learning disabilities: IDEA regulations. Retrieved from <http://idea.ed.gov/explore/view/p/,root,dynamic,TopicalBrief,23>,
- Walmsley, J. (2001). Normalisation, emancipatory research and inclusive research in learning disability. *Disability and Society*, 16(2), 187-205. doi: 10.1080/09687590120035807
- Watt, E., Murphy, M., Pascoe, E., Scanlon, A., & Gan, S. (2011). An evaluation of a structured learning programme as a component of the clinical practicum in final year bachelor of nursing programme: A pre-post-test analysis. *Journal of Clinical Nursing*, 20(15-16), 2286-2293. doi: 10.1111/j.1365-2702.2010.03621.x
- Wells, D.L. (1999). The importance of Critical Theory to nursing: A description using research concerning discharge decision-making. In E. C. Polifroni & M. Welch (Eds.), *Perspectives on philosophy of science in nursing: An historical and contemporary anthology* (387-394). Philadelphia, PA: Lippincott Williams & Wilkins.
- White, J. (2007). Supporting nursing students with dyslexia in clinical practice. *Nursing Standard*, 21(19), 35-42. Retrieved from http://www.researchgate.net/publication/6517141_Supporting_nursing_students_with_dyslexia_in_clinical_practice/links/0e5fdd91f0c404bcbfb2a9f8.pdf

- Wieland, D. M., Altmiller, G. M., Dorr, M. T., & Wolf, Z. R. (2007). Clinical transition of baccalaureate nursing students during preceptored, pregraduation practicums. *Nursing Education Perspectives*, 28(6), 315-321. dx.doi: [http://dx.doi.org/10.1043/1094-2831\(2007\)028\[0315:CTOBNS\]2.0.CO;2](http://dx.doi.org/10.1043/1094-2831(2007)028[0315:CTOBNS]2.0.CO;2)
- Wolff, A. C., Pesut, B., & Regan, S. (2010a). New graduate nurse practice readiness: Perspectives on the context shaping our understanding and expectations. *Nurse Education Today*, 30(2), 187-191. doi: 10.1016/j.nedt.2009.07.011
- Wolff, A. C., Regan, S., Pesut, B., & Black, J. (2010b). Ready for what? an exploration of the meaning of new graduate nurses' readiness for practice. *International Journal of Nursing Education Scholarship*, 7(1), 14p. doi: 10.2202/1548-923X.1827
- Wood, D., & Marshall, E. S. (2010). Nurses with disabilities working in hospital settings: Attitudes, concerns, and experiences of nurse leaders. *Journal of Professional Nursing*, 26(3), 182-187. doi: 10.1016/j.profnurs.2009.12.001
- Yonge, O., & Myrick, F. (2004). Preceptorship and the preparatory process for undergraduate nursing students and their preceptors. *Journal for Nurses in Staff Development*, 20(6), 294-297.
- Yonge, O., & Trojan, L. (1992). The nursing performance of preceptored and non-preceptored baccalaureate nursing students. *The Canadian Journal of Nursing Research*, 24(4), 61-75.

Appendix A: Study Protocol

Oregon Health & Science University
IRB Protocol # IRB00009629

Title: Transition to Clinical Nursing Practice for Persons with Learning Disabilities

Principal Investigator:
Dena Hassouneh, PhD

Co-Investigators:
Laura Mood, MSN, RN
Kristin Lutz, PhD, RN
Mary Schoessler, EdD

Purpose:

The purpose of this study is to understand and describe what transition to clinical nursing practice is like for students and new nurses with learning disabilities.

Recruitment and Subjects:

Purposeful, convenience sample of nursing students ($n = 4-8$) and new-licensed nurses (NL RNs) ($n = 2-4$) who self-report learning disability and who have experienced, or anticipate experiencing, a specific transition to clinical practice event. Total sample size will not exceed 20 participants. Study announcements will be made in multiple forms (verbal, paper-based flyers, electronic flyers, organizational social media pages, websites, and newsletters (pending approval by each organization). The language used in the study announcements will be the same no matter the approved route of communication (see Study Advertisement) with the exception classified advertisement where the study announcement will be published in an abbreviated form to meet space requirements of various media forms (see Classified Advertisement).

To gain access to potential NL RN participants, we will use existing community and/or professional relationships, as well as resources at OHSU school of nursing, to identify and make contact with nursing educators who are responsible for general nursing orientation and/or new graduate transition-to-practice programs at local hospitals. We will seek their approval to advertise the study and request their assistance in identifying the most appropriate means by which to get information to their NL RNs about the study. For example, we will seek approval from a hospital's nursing education department lead to make a verbal announcement of the study at their general nursing orientation, a paper-based announcement about the study in new nurse orientation packets, and/or electronic advertisement of the study on their nursing or education website. We will also place classified advertisements announcing the study in state board of nursing publications (e.g. OSBN Sentinel). Similarly for student recruitment, we will work with our professional networks to make contact with disability services personnel, school administrators, and/or faculty at targeted schools gain approval to advertise the study and to identify the most appropriate means by which to get

information to students about the study. For example, we will establish approval from such personnel to make a verbal announcement of the study at new student orientation or in specific courses, to post paper-based announcements in the school or wherever there is abundant student traffic on campus, or post/send electronic advertisement of the study via the school's website or through general student email distribution lists. In terms of student recruitment, we intend to target students who are accessing and/or receiving disability-related services as well as those who are not.

Potential participants will contact the researcher by phone or email if interested in participating in the study. The researcher will then complete a phone screening to ensure inclusion criteria is met. If potential participants meet inclusion criteria, the researcher will verbally review the purpose of the study, risks and benefits to participants, and confidentiality procedures. No personal identifying information will be collected from potential participants in written form during the phone screening until verbal consent for participation in the study is established. Participants volunteering to participate in the study must be: (a) Students in BSN programs who self-report LD with or without other co-existing conditions that may also impact their learning; or (b) Newly-licensed BSN RNs who self-report LD; or (c) BSN-prepared NL RNs who self-report LD and experienced an initial incomplete transition-to-work. All participants must also speak and understand English, have access to a phone or other necessary technologies (if distance interviewing is necessary), be 18 years or older, and able to provide written consent for their participation in the study. Excluded from this study are student nurses who are in associate degree nursing (ADN) programs and student nurses who have prior healthcare-related practice-based college degrees (e.g. medical assistant, surgical technician).

If potential participants meet inclusion criteria and verbally agree to participate in the study an initial interview will be scheduled with date, time, and place negotiated between the participant and researcher. Upon first meeting/interview conversation, the researcher will provide written and oral description of the purpose, procedure, and risks and benefits of the study.

Interview Procedure:

After participants agree to be included in the study an interview date, time, and location will be established. Upon the first meeting, participants will receive 2 copies of this consent form. They will be asked to read the consent form before the first interview, given time to ask any questions about the study, and asked to sign the form before the interview begins. They will submit one consent form to the researcher and be offered a copy for their own records. The researcher will confirm participants' understanding of their role, the risks and benefits related to participation in the study, and confidentiality procedures. The researcher will also ensure any questions participants have are answered before starting each interview.

Before the initial interview, each participant will be asked to complete a brief demographic survey that includes items like age, gender identity, ethnicity, socio-economic status, and school/employment disability disclosure status. In first interviews

participants will be asked to share information about their life history and experiences that led them to pursue a career in the field of nursing. In the second and third interviews (if applicable) participants will be asked about their transition to practice experiences in nursing including those already passed and those anticipated to come. Participants will also be asked about their disability identity and successes and/or challenges experienced in school or the workplace, including strategies or actions that helped or hindered their transition success. During interviews participants may also be asked to share available artifacts with the investigator. Such items may include course syllabi; transition-related educational documents or transition-to-practice program descriptions; orientation plans; job postings and applications; and RN job descriptions. The interview will be facilitated by the investigator using an interview guide. Each interview will last approximately 60-150 minutes, and be recorded using a digital voice recorder and field notes written by the attending investigator.

First interviews will be purposefully unstructured to provide an informal space for the researcher to get to know participants and their lives as they decide to tell them. A storyboard developed by the investigators will be used to set the stage for the first interviews with participants, giving them an idea of the investigators' understanding and interest in their stories.

Second and third interviews will be semi-structured to ensure specific focus on participants' current transition experiences. An interview guide developed by the investigators will be used that includes questions about participants' life experiences as well as those more recent and relevant to nursing and transition to clinical practice specifically. In semi-structured interviews, interview guides will not be strictly followed, but will be used flexibly and mainly to serve as an aid for staying close to the purpose of the research.

Protection of Human Subjects:

No personal identifying information will be collected from participants until verbal consent for participation in the study is established. Digital recordings and other electronic documents (e.g. interview transcripts) will be maintained as password protected files on the investigator's password-protected computer. Any hard copy documents will be stored in a locked file in the investigator's office. All forms and data files specific to each participant will be labeled with a pseudonym (alternate name selected by the investigator) and followed by a participant number (1-20) and interview/session number (1-3). (e.g. Sally, 1.1; Sally 1.2; Sally 1.3). The only list linking the participants' identities to their pseudonyms will be kept in an encrypted and password protected electronic file accessible to only the research team. Effort will be made to scan all paper documents and store them electronically. After scanning, any paper documents will be shredded and destroyed. Original digital recordings of interviews will be deleted from the investigator's computer hardware/software after transcription and subsequent verification by the research team. When data analysis is completed, the file linking the participant's identity and their pseudonyms will be deleted. When study data is transported outside of OHSU, the investigator will maintain it in a locked carrying case during travel periods. If

participating in this study becomes emotionally distressing for participants, they will be referred to student health at their school (if enrolled in a nursing program) or their employee assistance program (if employed) or a counselor of their choice in the community.

Data Safety/Management:

Digital recording of the interviews will be transferred from the portable recorder to a password protected computer in the researcher's locked office in the School of Nursing Building (Laura Mood, SON 573) immediately. The recordings will be sent to a professional transcription service that is compliant with the OHSU research confidentiality guideline via a password protected secure server, and the recorded interviews will be transcribed verbatim.

Interview transcripts will be reviewed by the researcher, and identifying information (e.g., personal and institutional names) will be replaced with pseudonyms or deleted before analysis if the researcher thinks it is irrelevant to the research purpose. Electronic files of the de-identified transcripts will be saved on the investigators' password protected computers until completion of the study, and then deleted completely thereafter.

Analysis

Data analysis will occur concurrently with data collection so as new ideas arise from the data they can be tested in subsequent interviews where relevant. Digital recording of the interviews will be transcribed verbatim, and transcripts, field notes, and artifacts (where available) will be included as part of data analysis. Data analysis will include descriptive, structural, thematic, and interpretive forms.

Interview transcripts will be analyzed independently by the PI and co-investigators to understand and delineate life histories inclusive of embedded social, cultural, and political norms and practices impacting the transition-to-practice experience of persons with learning disabilities pursuing careers in nursing. Research team members will analyze the data within and across cases until consensus is obtained. The investigators will meet regularly during interview and analysis phase, and primary coding/themes developed by the investigators' will be shared, examined, and integrated into one. Participants of the study will be asked to review the findings from analysis for member check to increase the trustworthiness of the findings.

At the end of analysis and interpretation the investigators will conclude a list of categories of lived experience, root metaphors, life-defining themes and truths, and pivotal turning points of participants' lives that have ultimately shaped their path to nursing, and specifically their transition-to-practice experiences within nursing school and in the workplace post-licensure. Exemplary narratives of each theme will be sought to support the investigators' findings.

Appendix B: Lay Language Summary

Purpose of this study

The purpose of this study is to understand and describe what transition to clinical nursing practice is like for students and new nurses with learning disabilities.

Participant recruitment

Baccalaureate-level nursing students and newly-licensed registered nurses (NL RNs) who self-report learning disability will be recruited for this study.

We (the PI and co-investigators) will first recruit within the Portland, OR metro area, then regionally within a 300 mile radius of Portland, Oregon. If further recruitment efforts are needed, they will be extended to neighboring states including Washington, Idaho, and California, within approximately a 300-1000 mile radius of Portland, Oregon. Finally, if these efforts do not provide a sufficient sample for this study, we will recruit nationally.

Student nurse recruitment. For student nurse recruitment, initially we will target baccalaureate-level students enrolled in nursing schools in the Portland, Oregon metro area. Within this locale there are six colleges and/or universities offering Bachelor of Science in Nursing (BSN) programs including: Concordia University; Linfield-Good Samaritan College; Oregon Health & Science University; University of Portland; and Walla Walla University. Beyond the metro area, there is George Fox University in Newburg, OR, and also OHSU's four regional campuses located across the state of Oregon in the cities of LaGrande, Klamath Falls, Ashland, and Monmouth. If an adequate sample does not emerge from the Portland-metro area, we will also target within Washington state students specifically enrolled in eight colleges and/or universities offering BSN programs including: Gonzaga University, Seattle Pacific University, Walla Walla College, Northwest University, Seattle University, Washington State University, Pacific Lutheran University, and University of Washington – Seattle. Though extremely unlikely, if a participant pool does not emerge from either the Portland-metro area, nor Washington (within 300 miles of Portland, OR), we will consider other possible student pools available outside of this perimeter in Washington, Idaho, and California, and nationally if needed.

To gain access to potential student participants at targeted schools, we will use our professional networks with the Association for Higher Education and Disability (AHEAD), both the national group as well as Oregon's chapter (OR-AHEAD). In addition, Student Access personnel at OHSU institution have agreed to assist us in connecting statewide with other school of nursing disability service centers and their representatives. Through these networks, we plan to initially make contact with disability services personnel, administrators, and/or faculty at targeted schools to identify the most appropriate means by which to get information to students about the study. For example, we will establish approval with school authorities to make a verbal announcement of the study at new student orientation, post paper-based announcements in the school or wherever there is abundant student traffic on campus, and/or

electronically advertise the study via the school's website or through general student email distribution lists. In terms of student recruitment, we intend to target students who are accessing and/or receiving disability-related services as well as those who are not.

NL RN recruitment. We will first target NL RNs employed in hospitals within the Portland-metro area. There are nine specific hospitals in this area including: Adventist Medical Center; Doernbecher Children's Hospital; Legacy Emanuel Medical Center; Legacy Good Samaritan Medical Center; Oregon Health & Science University Hospital (OHSU); Providence Portland Medical Center; Providence St. Vincent Medical Center; Portland Shriner's Hospital; and Veterans Affairs Medical Center.

If the NL RN participant pool from the local area is insufficient, then we will expand efforts beyond the Portland-Metro area to include other hospitals within Oregon (up to 300 miles away). There are 63 hospitals in the state of Oregon. Given the number of potential sites, we anticipate very little difficulty in recruiting NL RNs who work in Oregon for this study. However, if needed we will further investigate potential participant pools in hospitals outside the area, and consider expanding recruitment efforts to neighboring states and nationally. To gain access to potential NL RN participants, we will use existing community/professional relationships, as well as resources at OHSU school of nursing, to identify and make contact with nursing educators who are responsible for general nursing orientation and/or new graduate transition-to-practice programs at these local hospitals. We will request their assistance in identifying the most appropriate means by which to get information to their NL RNs about the study. For example, we will establish approval with hospital authorities to make a verbal announcement of the study at their general nursing orientation, include a paper-based announcement about the study in new nurse orientation packets, and/or electronically advertise the study on their nursing or education websites. We may also announce the study via classified advertisement in Oregon, Washington, and California state board of nursing publications.

Study announcements. Study advertisements for both the student and NL RN groups will include on-site verbal announcements, as well as paper-based, and electronic postings (e.g., e-mail, websites, Oregon State Board of Nursing's Sentinel, or social media) as approved. If it is necessary to extend recruitment efforts nationally, upon appropriate organizational permissions, we will also advertise the study via specific nursing-related conferences (e.g., national student nurses' association) and on websites targeted toward nursing students and/or nurses with disabilities (e.g., Exceptional Nurse; National Organization for Nurses with Disabilities; Society of Nurses with Disabilities). All study announcements will include a short description of the study and its purpose, an invitation to participate, and the investigator's contact phone number. The announcement will also inform potential participants that they will be issued a \$10 gift card upon completion of each interview in appreciation for their participation in the study. The language used in the attached study announcement for both the student and NL RN groups will serve all formats of messaging (including verbal announcements, paper flyers, and electronic notices), with the exception of classified advertisement.

Study announcements via classified ads will need to be abbreviated due to space limitations in various publications (see Classified Advertisement). If participants state they heard about the study from a classified ad, the investigator will communicate to the participant (verbally or electronically) the full study announcement prior to conducting the phone screening. Participants will make initial contact with the investigator. The investigators will not contact participants without their prior permission.

We plan to recruit participants on a rolling and continuous basis until, at minimum, all participant slots are filled in relation to the transition-to-practice (Transition-to-Practice) events identified below:

Transition-to-Practice 1 (first acute care clinical): Includes a minimum of two first or second-year baccalaureate nursing students

Transition-to-Practice 2 (focused preceptorship): Includes a minimum of two senior-year baccalaureate-nursing students

Transition-to-Practice 3 (first job as RN): Includes a minimum of two baccalaureate-prepared NL RNs. This group may also include NL RNs who experienced an initial incomplete transition-to-work post-licensure.

Total sample size will not exceed 20 participants. Once potential participants come forth and make contact with the investigator, participants will be screened via phone to ensure they meet designated inclusion criteria. If potential participants meet inclusion criteria, the researcher will verbally review the purpose of the study, risks and benefits to participants, and confidentiality procedures. No personal identifying information will be collected from potential participants in written form during the phone screening until verbal consent for participation in the study is established. Participants must be: (a) Students in BSN programs who self-report LD with or without other co-existing conditions that may also impact their learning; or (b) Newly-licensed BSN RNs who self-report LD; or (c) BSN-prepared NL RNs who self-report LD and experienced an initial incomplete transition-to-work. All participants must also speak and understand English, have access to a phone or other necessary technologies (if distance interviewing is necessary), be 18 years or older, and able to provide written consent for their participation in the study. Excluded from this study are student nurses who are in associate degree nursing (ADN) programs and student nurses who have prior health-care related practice-based college degrees.

Procedures

During the phone screening process, the researcher will provide an overview of the purpose, procedure, and risks and benefit of the study. Once a participant agrees via phone screening to participate in the study, an initial interview will be scheduled. Upon the first meeting, participants will receive 2 copies of the consent form. They will be asked to read the consent form before the first interview, given time to ask any questions about the study, and asked to sign the form before the interview begins. They

will submit one consent form to the researcher and be offered the other copy for their own records. The researcher will confirm participants' understanding of their role, the risks and benefits related to participation in the study, and confidentiality procedures. The researcher will also ensure any questions participants have are answered before starting each interview.

Before the interview begins, each participant will be asked to complete a brief demographic survey that includes items like age, gender identity, ethnicity, socio-economic status, and school/employment disability disclosure status. In first interviews participants will be asked to share information about their life history and experiences that led them to pursue a career in the field of nursing. In the second and third interviews (if applicable) participants will be asked about their transition to practice experiences in nursing including those already passed and those anticipated to come. Participants will also be asked about their disability identity and successes and/or challenges experienced in school or the workplace, including strategies or actions that helped or hindered their transition success. During interviews participants may also be asked to share available artifacts with the investigator. Such items may include course syllabi; transition-related educational documents or transition-to-practice program descriptions; orientation plans; job postings and applications; and RN job descriptions. The interview will be facilitated by the investigator using an interview guide. Each interview will last approximately 60-150 minutes, and be recorded using a digital voice recorder and field notes written by the attending investigator. Forms and data files will be labeled with a pseudonym (alternate name selected by the investigator) and followed by a participant number (1-20) and interview/session number (1-3). (e.g. Sally, 1.1; Sally 1.2; Sally 1.3). All electronic files will be password protected and hard copy documents will be stored in a locked file in the investigator's office. Effort will be made to scan all paper documents and store them electronically. After scanning, any paper documents will be shredded and destroyed.

Interview instruments

First interviews will be purposefully unstructured to provide an informal space for the researcher to get to know participants and their lives as they decide to tell them. A storyboard developed by the investigators will be used to set the stage for the first interviews with participants, giving them an idea of the researchers' understanding and interest in their stories.

Second and third interviews will be semi-structured to ensure specific focus on participants' current transition experiences. An interview guide will be used that includes questions about participants' life experiences as well as those more recent and relevant to nursing and transition to clinical practice specifically. In semi-structured interviews, interview guides will not be strictly followed, but will be used flexibly and mainly to serve as an aid for staying close to the purpose of the research.

Analysis

Data analysis will occur concurrently with data collection so as new ideas arise from the data they can be tested in subsequent interviews where relevant. Digital recording

of the interviews will be transcribed verbatim, and transcripts, field notes, and artifacts (where available) will be included as part of data analysis. Data analysis will involve producing a general description of stories told, an analysis of how each story is told, specific themes found within and across cases, as well as the investigators' interpretation of the embedded meanings held within participants' stories. Consistent with life history research, the goal of data analysis and interpretation in this study is to uncover categories of lived experience, root metaphors, life-defining themes and truths, and pivotal turning points of participants' lives that have ultimately shaped their path to nursing, and specifically their transition-to-practice experiences within nursing school and in the workplace post-licensure. Research team members will analyze the data individually first, and discuss with the team until consensus is obtained. Participants of the study will be asked to review the findings from the analysis for member check to increase the trustworthiness of the findings.

Appendix C: Study Announcement – Student Nurses

ATTENTION STUDENT NURSES!

OHSU RESEARCH STUDY ANNOUNCEMENT: PARTICIPANT RECRUITMENT OHSU-IRB #9629

APPROVED: Nov. 12, 2014

Study approval:

This study is approved by Oregon Health & Science University (OHSU) Institutional Review Board. The research is conducted by investigators at OHSU School of Nursing, 3455 SW US Veterans Hospital Rd. Portland, OR 97239-2941.

Purpose of research study:

To learn what pre- and post-licensure transition to clinical nursing practice (TTP) is like for nursing students who self-report learning disability (LD) as part of their experience.

Type of study/Participant requirements:

This is a qualitative research study. For participants, it requires 2-3 interviews with a focus on their personal life histories, as well as their current transition-to-practice experience. Each interview is estimated to last between 60 -150 minutes. Participants will receive a \$10 gift card in appreciation for their participation in the study (up to \$30). *The anonymity and confidentiality of participants will be protected throughout the research process and thereafter in any future published work.*

Participant criteria:

To qualify for participation in this study, you need to be a student enrolled in a baccalaureate nursing program who self-reports learning disability, and who:

(1) Will enter within the next six months a first clinical rotation in a hospital setting

OR

(2) Will enter within the next six months a senior-year preceptorship (also known as an immersion or integrated practicum experience).

Contact information:

If you are interested in volunteering to participate in this study, please contact Laura Mood, RN, PhD student @ 503-418-2518 or email moodl@ohsu.edu to confirm your eligibility and learn more. *Screening for eligibility is a confidential process, and prospective participants' anonymity will be protected.*

Appendix D: Study Announcement – NL RNs**ATTENTION NEWLY-LICENSED NURSES!**
OHSU RESEARCH STUDY ANNOUNCEMENT:
PARTICIPANT RECRUITMENT
OHSU-IRB #9629**APPROVED: Nov. 12, 2014****Study approval:**

This study is approved by Oregon Health & Science University (OHSU) Institutional Review Board. The research is conducted by investigators at OHSU School of Nursing, 3455 SW US Veterans Hospital Rd. Portland, OR 97239-2941.

Purpose of research study:

To learn what pre- and post-licensure transition to clinical nursing practice (TTP) is like for newly-licensed nurses who self-report learning disability (LD) as part of their experience.

Type of study/Participant requirements:

This is a qualitative research study. For participants, it requires 2-3 interviews with a focus on their personal life histories, as well as their current transition-to-practice experience. Each interview is estimated to last between 60 -150 minutes. Participants will receive a \$10 gift card in appreciation for their participation in the study (up to \$30). *The anonymity and confidentiality of participants will be protected throughout the research process and thereafter in any future published work.*

Participant criteria:

To qualify for participation in this study, you need to be a BSN-prepared newly-licensed nurse who self-reports learning disability, and who has either:

- (1) Started a first nursing job within the last 18 months; **OR**
- (2) Left a first nursing job within the last year

Contact information:

If you are interested in volunteering to participate in this study, please contact Laura Mood, RN, PhD student @ 503-418-2518 or email moodl@ohsu.edu to confirm your eligibility and learn more. *Screening for eligibility is a confidential process, and prospective participants' anonymity will be protected.*

Appendix E: Classified Advertisement**APPROVED: Mar. 4, 2014****PhD Student Seeks Assistance
With Nursing Research –
OHSU IRB#9629**

- BSN RNs with learning disability
- In practice 18 months or less
- 2-3 interviews to share life experience

Contact Laura Mood
PhD Student/Investigator
503-418-2518
moodl@ohsu.edu

Appendix F: Consent Summary & Form



IRB#:00009629

Protocol Approval Date: 11/22/2013

Research Consent Summary

You are being asked to join a research study. You do not have to join the study. Even if you decide to join now, you can change your mind later. If you decide to join, you will be asked to sign a consent form, which shows you give permission to be in the study.

1. The purpose of this study is to learn more about transition to clinical nursing practice.
2. We want to learn about:
 - a. the life histories of students and new nurses with learning disabilities.
 - b. personal stories of transition to clinical nursing practice.
 - c. preparation for transition to clinical nursing practice.
3. There is no sponsor paying for this research study.
4. If you join the study you will participate in two or three one-to-one interviews with the study investigator. These interviews will take place over a period of three to six months. Each interview will last approximately 60 to 150 minutes. The location of each interview will be decided by the participant and investigator with attention paid to the convenience, safety, and privacy of participants.
5. Interviews will be focused on participants' personal life histories, as well as past and present transition-to-practice experiences in nursing.
6. Participants' identities will be protected throughout the process and in any future publication or presentation of results. Despite these efforts, there is a small risk of breach of confidentiality. There is also a risk that participants may experience discomfort in talking about their experiences.
7. Information collected during the study will be solely used for this research study.



IRB#: 00009629

Protocol Approval Date: 11/22/2013

Research Consent Form

TITLE: Transition to Clinical Nursing Practice for Persons with Learning Disabilities

PRINCIPAL INVESTIGATOR: Dena Hassouneh, PhD (503) 494-2714

CO-INVESTIGATORS: Laura Mood, MSN (503) 418-2518

PURPOSE:

You have been invited to be in this research study because you are a nursing student or new nurse who has self-identified as having a learning disability, and who has recently experienced or will experience a transition to clinical practice. The purpose of this study is to understand and describe what transition to clinical nursing practice is like for students and new nurses with learning disabilities. This study requires 2 or 3 interviews lasting between 60 and 150 minutes each that will take place over a 3 to 6 month period of time. Up to 12 participants will be enrolled in this study.

We are asking you to provide information via interviews that will be stored in a data repository. This information will be stored until the study concludes.

PROCEDURES:

If you agree to participate, an initial interview will be scheduled. Upon notice of the scheduled interview date, time, and location, you will receive 2 copies of this consent form. You will be asked to read the consent form before the first interview, given time to ask any questions about the study, and asked to sign the form before the interview begins. You will submit one consent form to the researcher and keep another copy for your record.

At the first interview, you will be asked to complete a brief demographic survey that includes items like age, gender identity, ethnicity, socio-economic status, and school/employment disability disclosure status. In the first interview you will be asked to share information about your life history and experiences that led you to pursue a career in the field of nursing. In the second and third interviews (if applicable) you will be asked about your transition to practice experiences in nursing including those you've already

experienced and those you may be anticipating. You will also be asked about successes and or challenges you've experienced in school or the workplace, including strategies or actions that helped or hindered your success in transitions. During interviews participants may also be asked to share available artifacts with the investigator. Such items may include course syllabi; transition-related educational documents or transition-to-practice program descriptions; orientation plans; job postings and applications; and RN job descriptions.

All interviews will be facilitated by the researcher using an interview guide. Each interview will last approximately 60-150 minutes, and be recorded using a digital voice recorder and field notes collected by the investigator.

Within 3 months after your final interview, you will receive a summary of the interview and the investigator's analysis, and be asked to verify the contents are accurate and if they agree with the analysis. You will be asked to provide any comments on the summary.

Interview transcripts will only be shared with the research team involved in this study. Any personal information in the transcripts will be labeled as described in the CONFIDENTIALITY section.

During this study you will be audiorecorded during interviews. These recordings will be used ONLY for this research study, and they will be destroyed upon completion of data analysis.

If you have any questions regarding this study now or in the future, contact Dena Hassouneh at 503-494-2714 or other members of the study team at (503) 494-2518.

RISKS AND DISCOMFORTS:

Efforts will be made to keep your personal information confidential as described in the CONFIDENTIALITY section, but we cannot guarantee total privacy. There is a small chance that your information could be accidentally released.

During the interviews, some questions may seem very personal or embarrassing. They may upset you. You may refuse to answer any of questions that you do not wish to answer. If the questions make you very upset, we will help you to find a counselor.

BENEFITS:

You may or may not personally benefit from being in this study. However, by serving as a participant, you may help us learn how to benefit students and new nurses with learning disabilities in transition to clinical practice in the future.

ALTERNATIVES:

You may choose not to be in this study.

CONFIDENTIALITY:

We will take steps to keep your personal information confidential, but we cannot guarantee total privacy. Your audio-recorded interview will be professionally and securely transcribed per a Business Associates Agreement held by OHSU. All identifying information about you will be removed from the interview transcripts before they are released to any investigators other than ones named on this consent form.

Research records may be reviewed and copied by people involved in conducting or overseeing research including the OHSU Institutional Review Board, the Office for Human Research Protections (OHRP), or any other applicable agency.

All other parties including employers, insurance companies, and relatives will be refused access to your information unless you provide written permission or unless we are required by law to release it.

Under Oregon Law, suspected child or elder abuse must be reported to appropriate authorities.

We may continue to use and disclose your information as described above indefinitely.

COMMERCIAL DEVELOPMENT:

Information about you or obtained from you in this research may be used for commercial purposes, such as making a discovery that could be patented or licensed to a company. There are no plans to pay you if this happens. You will not have any property rights or ownership or financial interest in or arising from products or data that may result from your participation in this study. Further, you will have no responsibility or liability for any use that may be made of your information.

COSTS:

There will be no cost to you for participating in this study.

Participants will receive a \$10 gift card in appreciation for their time following each interview. The gift cards will be presented to participants at the end of each interview no matter if the investigator or participant (for whatever reason) stops the interview earlier than expected.

LIABILITY:

If you believe you have been injured or harmed while participating in this research and require immediate treatment, contact Dena Hassouneh (503) 494-2714.

You have not waived your legal rights by signing this form. If you are harmed by the study procedures, you will be treated. Oregon Health & Science University does not offer to pay for the cost of the treatment. Any claim you make against Oregon Health & Science University may be limited by the Oregon Tort Claims Act (ORS 30.260 through 30.300). If you have questions on this subject, please call the OHSU Research Integrity Office at (503) 494-7887.

PARTICIPATION:

If you have any questions regarding your rights as a research subject, you may contact the OHSU Research Integrity Office at (503) 494-7887.

You do not have to join this or any research study. If you do join the study and later change your mind, you have the right to quit at any time. If you choose not to join any or all parts of this study, or if you withdraw early from any or all parts of the study, there will be no penalty or loss of benefits to which you are otherwise entitled. Talk to the study investigator if you wish to withdraw from the study.

If you choose to withdraw from the study before completion, send a written request to the Principal Investigator listed on page one of this form. If in the future you decide you no longer want to participate in this research, we will remove your name and any other identifiers from your interview data, but the material will not be destroyed and we will continue to use it for research.

You may be removed from the study if the investigators stop the study, or you do not follow study instructions.

We will give you any new information during the course of this research study that might change the way you feel about being in the study.

The participation of OHSU students or employees in OHSU research is completely voluntary and you are free to choose not to serve as a research subject in this protocol for any reason. If you do elect to participate in this study, you may withdraw from the study at any time without affecting your relationship with OHSU, the investigator, the investigator's department, or your grade in any course. If you would like to report a concern with regard to participation of OHSU students or employees in OHSU research, please call the OHSU Integrity Hotline at 1-877-733-8313 (toll free and anonymous).

SIGNATURES:

Your signature below indicates that you have read this entire form and that you agree to be in this study.

We will give you a copy of this signed form.

**OREGON HEALTH & SCIENCE
UNIVERSITY
INSTITUTIONAL REVIEW BOARD
PHONE NUMBER (503) 494-7887
CONSENT/AUTHORIZATION
FORM APPROVAL DATE**

Nov. 12, 2014

**Do not sign this form after the
expiration date of: Nov. 11, 2015**

Participant Printed Name	Participant Signature	Date
Person Obtaining Consent Printed Name	Person Obtaining Consent Signature	Date

Appendix G. Demographic Survey

Question	Answer
How old are you?	
What is your race/ethnicity?	
How do you identify with regard to your gender?	
How would you characterize your (or your family's) current socio-economic status?	Circle one: <ul style="list-style-type: none"> • low-income • middle-income • high-income
What is your current role in nursing?	Circle one: <ul style="list-style-type: none"> • student nurse • new nurse
If you are a current or former student, have you ever disclosed any disability to officials at your school?	Circle one: <ul style="list-style-type: none"> • Yes • No
<u>For new nurses only:</u> If you are a new nurse, have you ever disclosed any disability to your direct supervisor at work?	Circle one: <ul style="list-style-type: none"> • Yes • No

Appendix H: Story Board & Interview Guide – Nursing Students

Thank you very much for meeting with me today.

My name is Laura Mood, I am faculty at OHSU School of Nursing, and an investigator on this study.

The purpose of this study is to understand and describe what transition to clinical nursing practice is like for students and new nurses with learning disabilities. You are invited to this study because you have self-identified as a nursing student with a learning disability, and who either experienced or anticipates a specific transition to clinical nursing practice.

The purpose of today's interview is to explore your life history to understand what experiences led you to where you are today – in pursuit of a career in nursing.

Interview 1: Storyboard – Exploring life histories [Nursing students]

I'm interested in learning about your transition to clinical nursing practice while in nursing school. It's my understanding that students typically transition in and out of different clinical settings each term or semester of their programs, and in the senior year there is usually an extended preceptorship or immersion required. I'd like to hear about the clinical learning experiences you've had in nursing school, specifically those that took place or that you anticipate will occur in the hospital setting. Though, today I want to start with your life story. Tell me about your life and how you came to be where you are today. You can start your story anywhere you like.

[NOTE: If participants need help getting started, I will have them spend a few minutes developing a timeline of their lives, identifying significant moments, milestones, turning points, and then ask them to share their stories of these events].

(Repeat underlined section at the beginning of the second interview.)

Interview #2 & #3 [Nursing students] Guide: Exploring the intersection of disability and transition to clinical nursing practice.

Last time, I learned about several memorable experiences in your life, and how you came about deciding to pursue a career in nursing. Based on what I learned from you last time, it sounds like many factors influenced this path, including XXX. Do I have that right? Today, I'd like to explore this further as well as specific details of your transition to nursing school, clinical nursing practice, and disability identity.

1. Specifically, tell me how you became interested in nursing as a career?
 - 1.1 Who influenced you in your decision to become a nurse?
 - 1.2 What kind of nurse do you want to be?
 - 1.3 What do you imagine your career path will look like after you graduate?

2. How do you define a transition?
 - 2.1 Tell me about a transition you've experienced in your life.
 - 2.2 How would you describe this experience overall?
 - 2.3 What did you learn (if anything) about yourself through this experience?
 - 2.4 Are there things you learned through this experience that helped you (or not) now in your transition to nursing school or the clinical setting?

3. You have identified yourself as someone with a disability. I'd like to hear more about your experience of disability.
 - 3.1 How do you refer to this disability?
 - 3.2 How would you describe your disability?
 - 3.3 How did you come to learn about it?
 - 3.4 What was life like for you before you learned about this disability?
 - 3.5 In what ways (if any) has disability affected your life; the decisions you've made in your life?
 - 3.6 In what ways (if any) has disability affected your clinical experiences in nursing school?

4. Have you disclosed your disability to anyone at your school? Why or why not?
If yes,
 - 4.1 What was that experience like for you?
 - 4.2 What (if any) accommodations have you sought or have been provided to you by the school?
 - 4.3 Tell me about the process you had to go through to get these accommodations.
 - 4.4 How have accommodations facilitated (or not) your learning in either the classroom or clinical setting so far in your program ?
If no,
 - 4.5 What stopped you?
 - 4.6 What do you think would happen if you did disclose?

5. If pre-transition:
 - 5.1 What do you imagine clinical learning will be like for you in the hospital setting you are going to be in for your upcoming clinical?
 - 5.2 Let's talk a bit about preparation for your upcoming clinical. What do you already know about the setting you are going to be in, if anything?
 - 5.3 What would you like to know before you arrive there on your first day?
 - 5.4 In what ways (if any) have you sought out this information ahead of time or have you otherwise prepared?
 - 5.5 What are your expectations related to this clinical placement?
 - 5.6 What, if anything, do you think would help maximize your learning in this setting?
 - 5.7 What, if anything, do you think will impede your learning in this setting?
 - 5.8 (If student has accommodations) How will the accommodations you have now be useful (or not) to you in this clinical setting?

6. If post-transition:
 - 6.1 What were your expectations related to this clinical placement?
 - 6.2 What was clinical learning actually like for you in this setting?
 - 6.3 Let's talk a bit about preparation for this clinical. What things did you know about the setting beforehand, if anything?
 - 6.4 What did you want to know before you arrived there on your first day, or any other day for that matter?
 - 6.5 In what ways (if any) did you seek out information about the clinical setting or the expectations related to learning in the setting ahead of time?
 - 6.6 What, if anything, do you think helped maximize your learning in this setting?
 - 6.7 What, if anything, do you think impeded your learning in this setting?
 - 6.8 (If student has accommodations) How did your accommodations work for you in this clinical setting?
 - 6.9 How has this clinical experience influenced your thinking about becoming a nurse or where you might like to work within nursing?

Summary

Do you have any comments, ideas, or suggestions for this study?

Our long term goal is to uncover practical knowledge and strategies for how nursing (the field in general, as well as faculty and clinical educators) can be more inclusive and supportive of persons with disabilities who are pursuing careers in nursing.

Do you have any further suggestions, ideas, or comments about how to make this happen?

Closing

This is the end of our interview today.

I will see you again on XX/XX from XX-XX for the second/third interview. Please let me know if you have any questions or concerns between now and next time.

Thank you very much for your participation in this study. Within 3 months from your final interview, you will receive a brief summary of the interviews and analysis. The summary report will include some instructions asking you to verify if the contents are an accurate reflection of your experiences and if you agree with the analysis. Submission of your comment sheet about the summary will be the completion of your study participation.

Again, thank you very much for your time and participation in the study.

(Non-underlined for the end of first interview. Underlined for the end of second interview.)

Appendix I: Story Board & Interview Guide – Newly-Licensed RNs

Thank you very much for meeting with me today.

My name is Laura Mood, I am faculty at OHSU School of Nursing, and an investigator on this study.

The purpose of this study is to understand and describe what transition to clinical nursing practice is like for students and new nurses with learning disabilities. You are invited to this study because you have self-identified as a newly-licensed nurse with a learning disability, and who either experienced or anticipates a specific transition to clinical nursing practice.

The purpose of today's interview is to explore your life history to understand what experiences led you to where you are today – in pursuit of a career in nursing.

Interview 1: Storyboard – Exploring life histories [Newly-licensed nurses]

I'm interested in learning about your transition to work. It's my understanding that new graduate nurses' transition to practice is a very individual experience, and that satisfaction with the experience is dependent on a host of factors. I'd like to hear about your transition to clinical nursing in the hospital setting. Though, today I was hoping we could start with your life story. Tell me about your life and how you came to be where you are today. You can start your story anywhere you like.

[NOTE: If participants need help getting started, I will have them spend a few minutes developing a timeline of their lives, identifying significant moments, milestones, turning points, and then ask them to share their stories of these events].

(Repeat underlined section at the beginning of the second interview.)

Interview #2 & 3 [Newly-licensed nurses] Guide: Exploring the intersection of disability and transition to clinical nursing practice.

Last time, I learned about several memorable experiences in your life, and how you came about deciding to pursue a career in nursing. Based on what I learned from you so far, it sounds like many factors influenced this path, including XXX. Do I have that right? Today, I'd like to explore this further including some specific details of your transitions in nursing school, to clinical nursing practice as a new graduate, and as someone who self-identifies as having a learning disability.

1. Specifically, tell me how you became interested in nursing as a career?
 - a. Who influenced you in your decision to become a nurse?
 - b. What kind of nurse do you want to be?
 - c. What do you imagine your career path will look like in the future?

2. How do you define a transition?
 - a. Tell me about a transition you've experienced in your life.
 - b. How would you describe this experience overall?
 - c. What did you learn (if anything) about yourself through this experience?
 - d. Are there things you learned through this experience that helped you (or not) through other times in your life?

3. You have identified yourself as someone with a disability. I'd like to hear more about your experience of disability.
 - a. How do you refer to this disability?
 - b. How would you describe your disability?
 - c. How did you come to learn about it?
 - d. What was life like for you before you learned about this disability?
 - e. In what ways (if any) has disability affected your life or the decisions you've made in your life?
 - f. In what ways (if any) has disability affected you as a new nurse?

4. What was nursing school like for you?
 - a. Did you disclose your disability to anyone at your school?
 - b. Tell me more about your decision.
 - c. What about transitioning in and out of different clinical settings during school – what was that like for you?

5. Tell me about the path that led you to your current job in nursing.
 - a. What was taking the NCLEX like for you?
 - b. What was the job hunting experience like for you?
 - c. What was hospital/nursing orientation like?
 - d. Are you involved in any NL RN transition to practice program?
 - e. What expectations did you have related to learning this job?
 - f. How did you prepare (or not) for this position?
 - g. Tell me about your typical day in orientation on the unit.

6. What successes have you had in learning your job? What about challenges (if any)?
 - a. What do you think contributed to these successes in entering the workplace?
 - b. What do you think might have eased these challenges you experienced during this transition?

7. Have you disclosed your LD in the workplace?
 - a. (If yes), to whom, and what was this experience like for you?
 - b. (If no), tell me more about your decision not to disclose.

8. Looking back, is there anything you wish you had known or done before taking this new position?

9. How has your experience in the workplace so far influenced your thinking about yourself as a nurse or what you might like to do as a nurse in the future?

Summary

Do you have any comments, ideas, or suggestions for this study?

Our long term goal is to uncover practical knowledge and strategies for how nursing (the field in general, as well as faculty and clinical educators) can be more inclusive and supportive of persons with disabilities who are pursuing careers in nursing.

Do you have any further suggestions, ideas, or comments about how to make this happen?

Closing

This is the end of our interview today.

I will see you again on XX/XX from XX-XX for the second/third interview. Please let me know if you have any questions or concerns between now and next time.

Thank you very much for your participation in this study. Within 3 months from your final interview, you will receive a brief summary of the interviews and analysis. The summary report will include some instructions asking you to verify if the contents are an accurate reflection of your experiences and if you agree with the analysis. Submission of your comment sheet about the summary will be the completion of your study participation.

Again, thank you very much for your time and participation in the study.

(Non-underlined for the end of first interview. Underlined for the end of second interview.)