EXAMINING THE IDENTITY VERIFICATION PROCESS AMONG REGISTERED NURSES

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EXAMINING THE IDENTITY VERIFICATION PROCESS AMONG
REGISTERED NURSES

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Thesis

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ABSTRACT

The extent to which there is congruence between one’s reflected appraisals and one’s self-perception has been shown to have both positive and negative emotional consequences. However, less is known about the effect of this identify verification process for emotion-based outcomes and among adult workers for whom identity and emotion may be particularly important. In addition, few studies have examined how these relationships hold for particular types of interactional partners, or how they may be moderated by varying degrees of identity salience and commitment. To further address these issues, I investigate these relationships among full-time registered nurses (RNs) employed within an acute care hospital system in the Midwestern United States. More specifically, I examine the emotional experiences of RNs whose nursing identities are not verified by their patients—an important interactional group with whom RNs spend a significant amount of their time and who are a direct counter-role to their role as a nurse. I also explore the moderating effects of identity salience and commitment on the relationship between a non-verified identity and positive, agitated, and negative emotional outcomes. Consistent with previous literature, I find that individuals whose nurse identities are not verified experience more negative and agitated emotions, and fewer positive emotions, than nurses who do experience identity verification, but that emotional commitment to the job will reduce this relationship between this identity discrepancy and agitated emotions. In addition, intensive commitment tends to strengthen...
the effect between a non-verified nurse identity and agitated emotions. Implications of the results for future research on identity and emotion are discussed.
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CHAPTER I
INTRODUCTION

The relatively high turnover rate and corresponding shortage of registered nurses (Brewer, Kovner, Green, and Cheng 2009; Kalisch, Lee and Rochman 2010) has remained an issue of concern in the United States for more than a decade. As a result, researchers have been increasingly interested in understanding the reasons behind these high turnover rates and what might be done to retain bedside nurses within acute care settings. Although the underlying causes are complex, a growing number of researchers have begun to emphasize the importance of self and emotion in understanding the experiences of frontline health care providers (e.g., Brewer et al. 2009; Erickson 2008; Stacey 2011; Theodosius 2008).

Although it has not been applied to the experiences of RNs or other frontline workers, identity theory (Burke and Stets 2009; Stryker 1980/2002) has the potential to provide theoretically-guided insights into these issues. As Stryker and Burke (2000) note the two prominent aspects of sociologically-based identity theory help to explain how one’s social location comes to influence self and how specific self-processes influence social behavior. More recently, identity theorists have offered up ways that emotion might be integrated into aspects of identity theory (Stets 2005; Stryker 2004). Stryker (2004) suggests, for example, that affective responses are likely to be more intense when one fails to meet expectations associated with a salient identity or when a person feels
highly committed to others through their role identity. In conducting initial tests of these and other relationships, researchers have demonstrated support for the connections between status, discrepancy, and emotion but also point out that the relationships are more “complex and contextual than originally thought” (Turner and Stets 2006, p. 220).

The current study extends theory and research on identity processes by examining how the lack of identity verification, or identity discrepancy, is associated with different types of emotional outcomes and how the relationship between discrepancy and emotional experience may be moderated by identity salience and three forms of commitment. Consistent with the idea that the context of interactions may be particularly important for understanding these processes, I investigate these relationships among a sample of RNs and in the context of their interactions with patients, a key counter-role for the nursing identity (Shattell 2004).

In that others have demonstrated that occupationally-based emotional experiences may be linked to such outcomes of interest as job burnout and satisfaction as well as mental health outcomes such as depressed mood (e.g., Erickson and Ritter 2001), greater understanding of the mechanisms through which on-the-job experiences translate into affective responses has the potential to positively impact nurses’ well-being and retention.
CHAPTER II
LITERATURE REVIEW

Role Identity

Identity theorists view identities as containing *self-relevant meanings* that act as standards for *who* one is in a given situation (Burke 1980, 1991; Burke and Tully 1977). There are three bases for identities including person identities, social identities, and role identities. In the sociological social psychology perspective, person identities are viewed as the unique meanings one gives to him or herself as an individual (Owens 2003). By contrast, social identities are meanings that individuals have for themselves in relation to broader social categories (e.g., nationality, race/ethnicity) (Hogg 2006).

Role identities, on the other hand, are the views that individuals have for themselves in relation to specific positions they hold (Stryker 1959; McCall and Simmons 1978). Social positions are statuses held by individuals in specific situations. Therefore, consistent with symbolic interactionism, identity theorists suggest that role identities help individuals answer the question, “Who am I?” (Thoits 2003). For example, in answering this question, one may refer to such role identities as spouse, worker, sibling, friend, child, parent, and so on. As a result, “nurse” serves as an example of a role identity rather than a social identity or a person identity.
Moreover, role identities are tied to behavioral expectations that can only emerge through social interactions with relevant others holding counter-roles (Burke 1999; McCall and Simmons 1978; Stryker 1959). An individual may have as many role identities as social positions he or she occupies, and for every role identity an individual occupies, there are counter-role identities which are held by others during interactions. For example, an individual who is a mother, a daughter, a wife, and a nurse may interact with those whom hold the counter roles to her role identities—in this case, she interacts with her child, mother, husband, and patient.

Because the interactions between roles and counter-role identities are embedded within social structure, individuals develop shared meanings for the behavioral expectations associated with each role and counter-role, some of which are more important to the individual than others (Burke and Tully 1977; Stryker and Serpe 1982). For instance, in Asencio’s (2011) study of criminal offenders, she argued that individuals may have several counter-roles for a given role identity. For example, counter-roles may include significant others (familiar others), those who are in relative positions of authority (legitimate others), and those who an individual spends the majority of his or her time with—e.g., peers (frequent others). She found that there was a stronger interaction with familiar and frequent others and one’s self-view than there was with legitimate others and one’s self-view (Asencio 2011).

Given that the workplace is the research site for the current study, the “others” who may have a strong impact on nurses’ self-views are their patients—since they are the group of individuals with whom direct care nurses spend the majority of their time interacting. In Asencio’s terms, they constitute “frequent others.” Although other RNs, as
“familiar others,” may also be important for the nurses’ self-views, I chose to examine nurses’ reflected appraisals of patients. This choice is consistent with ideas found in Erickson (2008) who emphasizes that the experience and management of emotions is particularly important for the quality of nurse-patient interactions and patient care – results which may be influenced by the well-being of the nurse herself.

Identity Theory and the Verification Process

Identity control theorists use a cybernetic model to demonstrate how cognitive and emotional processes contribute to an interactional feedback loop in which individuals seek to act and react towards others with appropriate behavior (Burke 1991). This cybernetic feedback loop is called the identity verification process, and is illustrated through the identity model. The identity model contains four major elements: identity standard, input, comparator, and output.

The identity standard is the set of self-relevant meanings that make up a person’s role identity. A person’s identity standard is defined by culturally shared meanings in combination with how an individual views herself fulfilling the meanings associated with a given identity. Through interactions with others, individuals will “engage in behavior to create meanings that correspond to the meanings of their identity standard” (Burke 2006: 82). In this study, the identity standard meanings for the nurse role involve, for example, being caring, selfless, and competent (Erickson and Diefendorff 2011). During social interaction, individuals will perceive others’ reactions to how well they embody these meanings (i.e. reflected appraisals) and compare them to their identity standard.
The input, on the other hand, allows a person to interpret information about his or her behavior through reflected appraisals. Reflected appraisals are an individual’s perceptions of how she believes others view her performance within a given identity; a person is only able to perceive the reactions of others by interpreting the verbal and nonverbal cues of the interactions she has with them. Therefore, an individual will work to confirm her identities by comparing her reflected appraisals with her identity standard meanings—the goal is to keep the identity standard meanings aligned with her reflected appraisals (Burke 1991).

The comparator judges the information from the input (i.e. the reflected appraisals) against the meanings held in the identity standard. If the perceptions from the input are consistent with the identity standard, then the individual’s identity (e.g., nurse) is verified. However, if through disturbances (e.g., others’ reactions or behavior, or changes in environmental circumstances) the individual experiences a discrepancy between the input and his or her identity standard, then that particular identity is not verified. For example, if a nurse views herself as highly caring, selfless, and competent but she believes others view her as incompetent, selfish, and uncaring, there is a discrepancy between the nurse’s identity standard and input from reflected appraisals.

When identity discrepancy occurs, the comparator signals an error, which may be brought into consciousness through the experience of negatively-valenced emotions (Burke 2008; Stets 2005). This error serves as an indicator to the individual to adjust his or her behavior within the environment in an attempt to realign reflected appraisals with the meanings held in the identity standard (Burke 1991). Therefore, the meanings of output behavior become more important than the actual behavior itself, as the behavioral
meanings are what change situational meanings (Burke and Reitzes 1981; Burke and Stets 2009). In more recent models of the identity verification process (e.g., Burke and Stets 2009), negative emotions are considered to signal “errors.” As individuals experience different levels of identity verification, emotional experiences—particularly negative emotional experiences—serve as signals to indicate the need for behavioral change (Burke 2008).

Experience of Emotions

Hochschild (1983) argued that emotions in the workplace were not only shaped by the individual, but also by the structure of the environment. By observing the emotional displays and experiences of flight attendants and bill collectors, Hochschild demonstrated how the context surrounding an interaction elicits feeling rules. Feeling rules are directed by cultural norms and inform individuals the extent to which they should display and experience various emotions. Lively (2009) emphasized that while identity theorists have made links between identity verification processes and the experience of emotion, few empirical studies have involved samples of workers in the context of their actual work environments. She argues that workplace dynamics, similar to family structures, include significant, and real, others who are embedded in status hierarchies within the organization, and these relationships are what make studying the real-life consequences of identity discrepancy on emotional experiences particularly important in the natural setting of the workplace—which laboratory experiments are unable to do.
Similar to McCall and Simmons’ (1978) discussion of emotions as outcomes, the perceptual control focus in identity theory explains that an individual who perceives an identity as not being verified will feel “bad,” and, therefore, the individual will suffer negative emotional consequences because he or she is failing to fulfill the expectations set forth by that role (Burke and Stets 2009; Stets and Tsushima 2001). In contrast, individuals whose identity is verified will experience feeling “good” and no behavioral or cognitive adjustments are necessary (Stets and Burke 2000; Stets and Tsushima 2001).

At issue are the discrepancies between reflected appraisals and identity standard meanings because if a role identity is not verified, the person is motivated to bring the identity standard in alignment with the perceived reflected appraisals through behavioral or cognitive processes to stop from experiencing negative emotions. Burke and Stets (2009:164) reiterate that regardless of the type of negative emotions, “the negative feelings motivate individuals to bring the system under conscious control and remedy the non-verifying state.” For example, in the context of nurses, an individual might change his or her behavior in an effort to receive reflected appraisals from patients that match his or her identity standard by behaving in a more caring way towards his or her patients. Alternatively, he or she may stop engaging in interactions with those who provide non-verifying feedback. In this case, the negative emotional consequences from discrepant feedback may have potential cognitive and structural (e.g., a person leaves the role) consequences. In the context of nursing, or potentially any other work role, the negative emotional experiences resulting from identity discrepancy may lead to poorer job performance or turnover.
On the other hand, a nurse may make cognitive adjustments by changing the way he or she views him or herself as a nurse so that is consistent with the reflected appraisals of patients. Although cognitive shifts are posited to be less likely to occur because behaviors are easier to adjust than cognitive processes, some empirical evidence suggests that these cognitive shifts can develop when a person repeatedly experiences identity discrepancy where the result is feeling negative emotions (Stets 2005).

Although the current study does not link emotional outcomes to behavioral or cognitive change, it does examine the verification-emotion connection among an important segment of the health care workforce (i.e., registered nurses). Given that few researchers have conducted studies among full-time, adult working populations using identity theory, the current study serves as a further test of the generalizability of the relationships between identity discrepancy and emotional experiences. Based on the preceding review of identity theory, I propose the following three hypotheses:

H1: Identity discrepancy will be negatively related to the experience of positive emotions.

H2: Identity discrepancy will be positively related to the experience of negative emotions.

H3: Identity discrepancy will be positively related to the experience agitated emotions.

Commitment and Salience as Moderating Variables

Burke (1991) and Burke and Stets (2009) note that the role of emotions is likely to be more complicated than experiencing negative feelings as a result of identity discrepancy and positive feelings from identity verification. Stryker (1968) and Burke
(1991) suggest that the experience of emotion that results from the identity verification process will vary in strength depending on the degree of commitment to that role identity. Similar to identity commitment, identity salience may condition the effect of identity verification on emotion-based experiences (Stryker 1968; Burke 1991). Therefore, identity verification processes should be able to specify the conditions under which an individual is likely to experience negative or positive emotions.

Identity theory concepts of commitment and salience are critical for the specification of these more complex relationships. For example, Burke and Reitzes (1991) found that individuals with high commitment to their role as students had stronger linkages between their identity standard meanings and corresponding behaviors than those who were less committed to their student role. In relation to mental health, Marcussen, Ritter, and Saffron (2004) found that commitment and salience within student identities strengthened the effect of stress on self-evaluation and psychological distress.

**Commitment**

In general, commitment is viewed as the measure of ties to others within social structure (Serpe 1987; Stryker 1968) and may be defined as “a binding tie between an individual and some other social entity, whether an identity, another individual, a group or organization, or an individual” (Burke 1991: 2). Stryker and Serpe (1982) discuss commitment in two ways: (1) one’s ties to the social structure through the number of other persons linked to an identity (termed interactional or extensive commitment); and (2) the strength of those ties embedded in a particular identity (termed affective or intensive commitment). They argue that an individual will be more likely to be
committed to a role identity if, for example, they have many ties to counter-role identities or if the ties they have are strong. In addition, individuals will be more committed to role identities if they are verified than if they are not verified by others as they consider the costs and rewards (termed cognitive commitment) of being in a particular role (Burke and Reitzes 1991; Stets and Burke 2003). Taken together, commitment can be seen as the interactional, affective, and cognitive costs incurred when an individual does not play out a role identity, and therefore, highly committed individuals experience strengthened consequences for not playing out their role adequately (Burke and Reitzes 1991). Consistent with previous literature on the function of identity commitment, I propose the following hypotheses:

H4: Cognitive commitment will:
(a) *reduce* the relationship between identity discrepancy and the experience of positive emotions;
(b) *increase* or amplify the relationship between identity discrepancy and the experience of negative emotions; and
(c) *increase* or amplify the relationship between identity discrepancy and the experience of agitated emotions.

H5: Extensive (interactional) commitment will:
(a) *reduce* the relationship between identity discrepancy and the experience of positive emotions;
(b) *increase* or amplify the relationship between identity discrepancy and the experience of negative emotions; and
(c) *increase* or amplify the relationship between identity discrepancy and the experience of agitated emotions.

H6: Intensive (affective) commitment will:
(a) *reduce* the relationship between identity discrepancy and the experience of positive emotions;
(b) *increase* or amplify the relationship between identity discrepancy and the experience of negative emotions; and
(c) *increase* or amplify the relationship between identity discrepancy and the experience of agitated emotions.
Salience

Stryker (1968; 1980/2002) first argued that identity salience, or one’s likelihood of enacting a role across various situations, was a good indicator for how likely a role is to affect behavior. If a role is salient to an individual, this means that it is often activated across a variety of situations, regardless of the relevancy of the context and may have a stronger impact on an individual’s well-being if it is challenged (Marcussen et al. 2004; Stryker and Serpe 1982). How likely one is to perform a role or tell others about that role may also influence emotional experiences when an individual experiences identity discrepancy with others (Stryker and Burke 2000; Stryker and Serpe 1982).

For example, if an individual invokes her identity as a nurse across various contexts, such as when meeting someone at a party or meeting a family friend for the first time, but the nurse does not perceive others as seeing her as a legitimate nurse, then the interaction of her nurse role being salient combined with this discrepancy may exacerbate her experience of negative emotions and buffer, or reduce, her experiences of positive emotions more so than if she did not view her nurse role as salient (Stryker and Burke 2000; Stryker and Serpe 1994).

While previous researchers have begun to explore the moderating effects of commitment and salience between discrepancy and the stress process in student samples (Marcussen et al. 2004), little is known about how salience moderates non-verified identities and the experience of negative, agitated, and positive emotions among adults in the workplace. Consistent with identity theorists who propose that, like commitment,

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1 Salience is not the same as centrality, in which the individual ranks his or her identities, in general, to which is most important to an individual, rather than understanding the contexts in which it is invoked (Marcussen et al. 2004; Owens 2003; Rosenberg 1979).
salience is likely to affect the experience of emotion when an individual experiences identity discrepancy, I propose the following hypotheses:

H7: Salience will:
(a) reduce the relationship between identity discrepancy and the experience of positive emotions;
(b) increase or amplify the relationship between identity discrepancy and the experience of negative emotions; and
(c) increase or amplify the relationship between identity discrepancy and the experience of agitated emotions.

In sum, I expect that nurses who experience identity discrepancy will likely report more negative emotions under conditions of higher salience and commitment. This could mean that a lack of commitment and lack of salience to the nurse identity could provide some insight on the high turnover rates among nurses. Therefore, I test the moderating effects of both role identity commitment and role identity salience on the relationship between identity discrepancy and emotional experiences within the nursing role.
CHAPTER III

METHOD

Sample and Analytical Strategy

The data used for the current research was drawn from a sample of RNs who were part of a larger NSF-funded study (SES-1024271) conducted by Erickson and Diefendorff (2011). The larger study examined various aspects of identity, emotional experience, and emotion management among direct care nurses employed within different hospitals of a unified health system located in the Midwestern United States. A complete listing of full-time (i.e., 36 hours or more per week), RNs was obtained from the unit managers of each hospital within the organization. A written questionnaire was distributed to all RNs within each hospital ($N = 1702$). Approximately 45% of the nurses returned a completed questionnaire. This response rate is comparable to those reported in other studies of RNs working within acute care settings (e.g., Lucero, Lake and Aiken 2010).

The sample used in this study consisted of responses from 775 RNs for whom complete data were available on the variables of theoretical interest. Of these 775 nurses, approximately 91% were female, 88% were Caucasian, and 62% held a Bachelor’s degree. The mean age of respondents was 41 years old with an average of 12.9 years of RN experience.
Ordinary Least Squares regression analysis was used to examine the hypothesized relationships between identity discrepancy and the experiences of agitated, negative, and positive emotions in the context of individuals’ role identity as a nurse. One aspect of this study that was of particular interest was exploring the moderating effects of commitment and salience on these relationships. Following the estimation of direct effects, and for each of the three emotion outcomes, I tested for interactions between RN-Patient identity discrepancy and cognitive commitment, intensive commitment, extensive commitment, and identity salience. In this way, I was able to investigate whether the experience of agitated, negative, and positive emotions was significantly strengthened or reduced by commitment and salience (Burke and Reitzes 1991; Marcussen et al. 2004).
CHAPTER IV
MEASURES

Emotional Experiences

I examined the impact of identity discrepancy on three measures of emotional experience: agitated, negative, and positive emotions. To measure these outcome variables, RNs were asked how intensely they felt the following emotions while at work in the last week: afraid; angry; anxious; ashamed; calm; excited; frustrated; guilty; happy; helpless; irritated; proud; relaxed; sad; surprised. Response categories ranged from 0 (not at all) to 5 (very intensely).

Following Erickson and Ritter (2001), I conducted a factor analysis to determine the factor structure of these emotional experiences. Although the loadings generally paralleled those of Erickson and Ritter, “surprise” (an emotional experience not included in the earlier study) did not load on any of the three factors and was removed from all further analyses.

The remaining emotional experience items all generated factor loadings that were consistent with previous research (Erickson and Grove 2008; Erickson and Ritter 2001). That is, angry, frustrated, and irritated loaded on factor one (agitated emotions), which had a Cronbach’s alpha reliability of .87. In addition, calm, excited, happy, proud, and relaxed loaded on factor two, positive emotions (Cronbach’s alpha = .83). Finally, afraid,
anxious, ashamed, guilty, helpless, and sad loaded on factor three, *negative emotions*, and had a reliability of .74.

*Identity Verification*

Stets and Burke (2003) emphasized that in order to be consistent with the identity theory view that the “input” to the identity verification process should be measured as reflected appraisals, rather than actual appraisals from others. To get at this, identity discrepancy was operationalized by taking the absolute difference between two sets of perceptions measured using semantic differential scales. First, RNs were asked to rate how they saw themselves “as a nurse” using a semantic differential scale adapted from Erickson (2008). The bipolar meanings that anchored each end of the five-point the scale were: caring-uncaring, disorganized-organized, dishonest-honest, observant-inattentive, selfish-selfless, critical-accepting, group oriented-individualistic, and incompetent-competent. Using the same semantic differential format and response categories, RNs were then asked how they believed patients viewed them in their role as a nurse.

To calculate the level of identity discrepancy, responses were coded such that higher scores meant favorable characteristics and lower scores meant the nurse was seen as having lower degrees of favorable characteristics. Absolute difference scores were calculated between the responses for each of the characteristics (Stets and Harrod 2004). Once these eight absolute difference scores were obtained they were summed to create the RN-Patient identity discrepancy scale. In this case, the comparator component of the identity verification process was captured through the absolute value of each individual’s “identity-standard meaning minus the perceptions of others” (Burke and Stets 2009: 226).
The larger the absolute difference, the greater the nurse experienced identity discrepancy in reflecting on her interactions with patients (Cronbach’s alpha = .79).

*Commitment*

Identity theorists suggest using various combinations of items to measure commitment. Therefore, measures of commitment were adapted from several identity theorists (Burke and Reitzes 1991; Stryker and Serpe 1982, 1994). They suggest using cognitive bases of commitment and socio-emotional bases of commitment (*extensive* and *intensive*) to tap into the aspects of rewards/costs, interaction, and affect associated with the nurse role identity. For the following 11 items, responses ranged from 1 (strongly disagree) to 4 (strongly agree). A scale was created for each of the three types of commitment by summing the responses to the relevant items. High scores indicated higher levels of commitment and low scores indicate lower levels of commitment for the nurse role identity.

Following Burke and Reitzes’ (1991) format, there were five reward/cost items that measure one’s level of *cognitive commitment* to the nurse identity. RNs were asked how strongly they agreed or disagreed that: (1) they received a great deal of satisfaction and fulfillment from being a nurse; (2) they felt being a nurse was very beneficial and rewarding in terms of the future; (3) people said they were right to think being a nurse was important; and (4) they received praise for being a nurse (Cronbach’s alpha = .81).

There were two items used to measure *extensive* (interactional) commitment. RNs were asked how strongly they agreed or disagreed that: (1) they would miss a lot of
people if they stopped being a nurse; and (2) they had made a number of friends through being a nurse ($r = .551; p < .01$).

Finally, there were four items that made up intensive (affective) commitment. RNs were asked how strongly they agreed or disagreed that: (1) no longer being a nurse would result in people closest to them being unhappy; (2) their best friends would be unhappy if they was no longer a nurse; (3) they would feel offended if someone said something bad about nurses in general; (4) they would be upset if friends and family no longer thought of them as a nurse; and (5) they perceived that others would be disappointed if they failed as a nurse (Cronbach’s alpha = .77).

**Salience**

Salience is an indicator of how likely a role identity is to be enacted across various contexts (McCall and Simmons 1978; Stryker and Serpe 1994). Salience is associated with the level of importance of an identity relative to others. Role identities that hold higher levels of importance are more likely to be enacted across a variety of contexts (McCall and Simmons 1978; Stryker and Serpe 1994).

To measure the salience of the RN identity, respondents were asked how certain they were that they would tell others that they were a nurse relative to other possible role identities (i.e. being a member of a group, being a spouse or partner, being a parent, and being a friend) within three different scenarios: (1) Meeting someone at a party for the first time; (2) meeting a co-worker for the first time; and (3) meeting a friend of a family member for the first time. The responses for each of these items ranged from 1 (almost certainly would not) to 4 (almost certainly would). Consistent with Stryker and Serpe
(1982, 1984), responses were summed across the three interactional scenarios with higher scores indicating higher levels of salience for the nurse identity and lower scores indicating lower levels of salience for the nurse identity (Cronbach’s alpha = .81).²

Control Variables

In addition to the variables operationalized above, I controlled for variables that have been linked to the nursing occupational context, and that may influence the experience of emotions and the quality of patient care via the reflected appraisals of RNs by patients (Lucero et al. 2010; Erickson 2008). First, the gender of respondent was measured by asking, “What is your gender?” The item was scored 1 for male and 0 for female. Consistent with the work of Aiken and her colleagues (2003), respondents’ educational level was measured by asking, “What is the highest level of education you have completed?” The responses were coded 1 (a diploma from a School of Nursing), 2 (an Associate’s degree), 3 (a Baccalaureate college degree) and 4 (a graduate degree), and were treated as a continuous variable. Years of experience as an RN were measured by asking, “How long have you been working in your current job?” RNs provided numerical responses in years and months.

In addition, Lucero et al. (2010) have shown that the quality of patient care by a nurse is influenced by the level of education and experience, which may affect the perceived attitudes of the patients towards one’s role as a nurse in acute care hospitals. I controlled

² Because the item referencing co-workers might operate somewhat differently for the work-related nursing identity when compared to the other two items, tests for mean differences were conducted. These indicated that each of the items’ means were significantly different from one another at the $p \leq .001$ level and that while the party and friend of the family items were more highly correlated, differences with the co-worker item were not large enough to warrant dropping the item from the final scale.
for contextual factors specific to the nursing environment and consistent with those used by previous researchers that may influence emotional experiences at work: patient load and time spent with patients. Patient load was measured by asking, “What is your patient load for direct care (on a typical shift)?” Time spent was measured by asking, “What percentage of time do you typically spend with patients per shift?” These were open-ended questions and were each measured as continuous variables. Lower scores indicated a lower patient load and less time spent with patients, and higher scores indicated a heavier patient load and a higher percentage of time spent with patients.
CHAPTER V
RESULTS

Table 1 shows the means and standard deviations for all variables, and Table 2 shows the correlations between all variables. As seen in Table 1, about 9% of the nurses were male, and 12% were racial minorities. On average, these nurses had 12.9 years of experience, and had received education beyond high school. In addition, the average nurse cared for about 4 patients and reported spending about 64% of their time with patients during a typical shift.

Shown in Table 2, nurses with more years of experience as an RN tended to experience fewer agitated and negative emotions, and nurses with higher levels of education experienced more agitated and negative emotions. In addition, there was a negative correlation between the amount of time RNs spent interacting with patients during a typical shift and the experience of negative and agitated emotions.

Table 2 also shows that intensive commitment was positively correlated with experiencing positive emotions (.085; p< .05). Extensive commitment was positively associated with experiencing positive emotions (.298; p< .001), and it was negatively associated with experiencing negative emotions (.298; p< .001). Cognitive commitment was negatively correlated with the experience of both agitated (-.252; p<.001) and negative emotions (-.219; p< .001), and was positively correlated with the experience of
positive emotions \( (.338; p < .001) \). Identity salience was positively correlated with positive emotions \( (.121; p < .01) \) and agitated emotions \( (.075; p < .05) \). Finally, higher levels of identity discrepancy was associated with the experience of more agitated emotions \( (.181; p < .001) \), more negative emotions \( (.182; p < .001) \), and fewer positive options \( (-.110; p < .01) \). These last results provide initial evidence in support of Hypotheses 1, 2, and 3.

Table 3 presents the regression of positive emotions on demographic characteristics, job characteristics, and identity discrepancy. As indicated, identity discrepancy between nurse and patient was significantly associated with a decrease in the experience of positive emotions \( (b = -.194; p < .01) \). Thus, Hypothesis 1 was supported.

In addition, Table 4 presents the regression of negative emotions on demographic characteristics, job characteristics, and identity discrepancy. As expected, RN-Patient identity discrepancy was strongly and significantly associated with an increase in the experience of negative emotions \( (b = .284; p < .001) \). Hypothesis 2 was supported. Finally, as seen in Table 5.1, Hypothesis 3 was also supported. That is, RN-Patient identity discrepancy was significantly associated with an increase in the experience of agitated emotions \( (b = .245; p < .001) \).

Table 5.2 also shows that there was a significant interaction between identity discrepancy and intensive commitment on agitated emotions \( (b = -.028; p < .10) \). Figure 1 illustrates this interaction effect. Specifically, when intensive commitment is high the effect of high identity discrepancy on the experience of agitated emotions is reduced. The results indicate that the interaction of intensive commitment and identity discrepancy significantly reduced the experience of agitated emotions. This result is the opposite of the expected relationship for Hypothesis 6c. There were no other significant interaction effects of intensive commitment,
cognitive commitment, extensive commitment, or salience on the relationship between identity discrepancy and reported emotional experience. As a result, the remaining hypotheses were not supported.
CHAPTER VI
DISCUSSION

Consistent with previous findings, identity discrepancy appears to be correlated with the experience of fewer positive emotions and more agitated and negative emotions. However, my results showed no support for the hypothesized interaction effects of salience and the various types of commitment. One possible explanation for the lack of support for these hypotheses is that using the standardized measures for commitment and salience, which have typically been used on student samples or in controlled experiments, may not have been adequate for use with adult samples in an occupational context.

For example, the standardized measure for salience asks how likely an individual would be to tell a co-worker she met for the first time that she was a nurse. When the context is the occupation of nursing, a question worded in this way may not accurately reflect how salient the nurse identity is to that individual. Instead, a measure of salience may have been operationalized as, “In a given week, how often outside of work do you talk to a) friends, b) family members and partners, c) acquaintances, and d) strangers about topics related to you being a nurse?” A question like this may have more accurately addressed the likelihood of an enacting an identity with various interactional partners within various contexts by removing the workplace (in which a nurse identity will be
inevitably salient) and including all types of partners, rather than simply new interactional partners one might meet for the first time.

Another possible explanation for the lack of support for my hypotheses was that, while I differentiated agitated emotions from negative emotions (Erickson and Ritter 2001), the measures of emotional experience could have been specified further. For example, had I looked specifically at the experiences of sadness or guilt, I may have found interactive relationships between commitment and salience with identity discrepancy, even if such a result was not generally found for “negative” emotions. Finally, the results may have been more revealing for nurse outcomes if I had used measures of distress as dependent variables (e.g., depressive symptoms) rather than emotions. For instance, Marcussen and her colleagues (2004) found significant support for the interaction of high cognitive commitment on measures of strain for increasing depressive symptoms. Therefore, future research on this topic should not only explore specific emotions as outcomes, but also distress-related outcomes among nurses whose identities are not verified by others in order to see if commitment and salience are interacting with identity discrepancy to affect nurses’ well-being.

Moreover, identity theorists have suggested that there is an interaction, or moderating effect, between identity commitment, identity salience, and the effect of identity discrepancy on individual outcomes such as emotional experiences. They suggest, for example, that those individuals who are highly committed to a given identity will tend to experience more negative emotions if that identity is not verified (Burke and Reitzes 1991; Stets and Burke 2003). Although the majority of my hypotheses showed no significant results, my findings did reveal one significant effect, but in the opposite
direction of what has previously been theorized. Specifically, being emotionally attached (i.e. intensively committed) to the occupational role of a nurse tends to decrease, rather than increase, the intensity of experiencing agitated emotions when an individual receives highly discrepant feedback.

Although researchers have pushed for the need to explore social, role, and person identities simultaneously (Stryker and Burke 2000) few researchers have taken on this challenge (e.g., Stets and Harrod 2003; Thoits 2004). The finding that intensive commitment tended to reduce the experience of agitated emotions when nurses received non-verifying feedback from patients may be explained by examining the nurse identity, not only as a role identity, but also a social and person identity. That is, if an individual not only considers being a nurse a role identity, but also a person identity that uniquely defines who she is and how she behaves in every-day life, and/or a social identity that helps her define her place in society, it is possible that discrepant feedback from patients will not produce more anger, frustration, or irritation in the nurse due to other verification processes that are at play.

When a nurse is so affectively attached to being a nurse that it overlaps with her person and social identities, she may think of the characteristics of a nurse (e.g., being caring, self-less, and competent) as also being a part of who she is as a person and how she fits into the social world. Her affective commitment to those overlapping person, social, and role identities may encourage her to seek verifying feedback from other people besides patients, such as family members or friends who see her as a caring and competent person. Therefore, future researchers should examine how multiple or
overlapping identities and verification processes work to reduce agitation in intensively committed nurses even when receiving nonverifying feedback from patients.

However, researchers may still be able to explain this theoretically inconsistent finding as well as explore the lack of support for many of the proposed hypotheses by examining alternative sources of feedback from frequent, authoritative, and familiar others. For example, feedback that a nurse receives from other nurses or from doctors may have a greater impact on self-processes for the nurse role identity than feedback from patients. Future researchers should show how emotions are experienced when the discrepant feedback comes from authoritative others (e.g., doctors) or alterative frequent others (e.g., coworkers) because Asencio (2011) and Stets and Harrod (2004) found that the source of the discrepant feedback matters in how individuals experience emotions.

It will be important to examine if the experience of positive, negative, and agitated emotions is strengthened or weakened if the source of discrepant feedback comes from co-workers or doctors rather than patients. Alternatively, examining the emotional outcomes of non-verified identities for opposing status groups, such as managers versus RNs, racial minorities versus whites, and males versus females may be particularly helpful for understanding burnout and turnover among nurses (Erickson and Grove 2001; Erickson and Ritter 2001).

Race and gender may be particularly useful in understanding how the self is affected by the identity verification process, as well as in exploring the influence of multiple identities as previously discussed. Support for examining race and gender show up in the findings of this study, though they were not included in my hypotheses. The
results indicate that gender is significantly related to the experience of positive emotions, and that race is significantly related to the experience of negative and agitated emotions.

Illustrated in Table 3, compared to women, men tended to be happier at work. This result for positive emotions supports Stets and Cast's (2007) suggestion that resources, specifically structural resources like gender, are important to the identity verification process and emotional experiences. On the other hand, Tables 4, 5.1, and 5.2 indicate that, compared to white nurses, racial minorities tended to experience marginally fewer negative emotions while at work. Hochschild (1983) argued that in service-related jobs, women’s emotional experiences are distinct from men’s, which is, in part, due to the gendered expectations associated with gendered jobs. Similarly, racial expectations or ideologies about work in general, and specific jobs may also differ, leading one group to experience fewer negative emotions than another group (Stacey 2011). Why speculated, researchers should ask, “How do race and gender interact with the nurse identity?” Asking questions about race and gender in the context of nursing when studying multiple identities should be considered in future research examining the impact of the identity verification process on nurses’ well-being.

Finally, recent research on identity theory has found empirical support for the self-enhancement principle, which states that identity discrepancy in a positive direction (i.e., in which the reflected appraisals are more positive than the identity standard meanings of a role identity) will produce more positive emotions under certain circumstances (Stets 2005; Stets and Asencio 2008). Because identity discrepancy was measured here by taking the absolute difference between reflected appraisals and identity standard responses, I was unable to examine the underlying mechanisms of the self-
enhancement processes which may have strengthened positive emotional experiences through identity salience and commitment. As such, this possibility should be explored in future research.

While there are still many areas to explore in identity theory, my study demonstrates support for the identity model in that having a non-verified RN identity has real negative impacts on emotional well-being. In addition, my results may suggest that nurses must develop passion for their job (i.e. have intensive commitment) to buffer the agitated emotional outcomes that emerge from receiving feedback from their patients that they are not performing as a nurse the way they believe themselves to be performing. In addition, nurses may consider developing quality relationships with the patients they see most often to avoid RN-patient identity discrepancy, and thus experiencing negative and agitated emotions at work.
REFERENCES


Erickson, Rebecca J. and James M. Diefendorff. “Understanding the RN Experience: Initial Results from the CARMA Project.” Interim Report, Baseline Data and Initial Recommendations. Submitted to Nursing Administration, University Hospitals Health System. (Project funded by the National Science Foundation, SES-1024271).


Table 1. Means and Standard Deviations for all variables.

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<thead>
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<th>Variables</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
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<td>0.325</td>
</tr>
<tr>
<td>2. Male RNs</td>
<td>0.092</td>
<td>0.289</td>
</tr>
<tr>
<td>3. Years as RN</td>
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<td>11.998</td>
</tr>
<tr>
<td>4. Education</td>
<td>2.73</td>
<td>0.678</td>
</tr>
<tr>
<td>5. Patient Load</td>
<td>4.154</td>
<td>2.504</td>
</tr>
<tr>
<td>6. Percentage Time w/Pts</td>
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<td>25.359</td>
</tr>
<tr>
<td>7. Perceived Workload</td>
<td>13.071</td>
<td>2.728</td>
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<tr>
<td>8. RN-Patient Identity Discrepancy</td>
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<td>2.451</td>
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<td>10. Intensive Commit.</td>
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<td>3.009</td>
</tr>
<tr>
<td>11. Extensive Commit.</td>
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</tr>
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<td>12. Identity Salience</td>
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<td>13. Positive Emotions</td>
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<td>4.922</td>
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<td>14. Negative Emotions</td>
<td>5.15</td>
<td>4.441</td>
</tr>
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<td>15. Agitated</td>
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(N=775)
Table 2. Correlation Coefficients for All Variables (N=775)

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<th>4</th>
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<th>13</th>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. Male RNs</td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>3. Years as RN</td>
<td>-0.059</td>
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<td></td>
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<tr>
<td>4. Education</td>
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<td>5. Patient Load</td>
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<td>6. Percentage Time w/Pts</td>
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<tr>
<td>7. Identity Discrepancy</td>
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<td>0.009</td>
<td>-0.071*</td>
<td>0.031</td>
<td>0.013</td>
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<tr>
<td>8. Cognitive Commit.</td>
<td>0.069</td>
<td>-0.042</td>
<td>-0.036</td>
<td>0.035</td>
<td>0.017</td>
<td>0.028</td>
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<tr>
<td>9. Intensive Commit.</td>
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<td>0.009</td>
<td>-0.094**</td>
<td>-0.041</td>
<td>0.046</td>
<td>0.014</td>
<td>-0.024</td>
<td>0.221***</td>
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<td>10. Evasive Commit.</td>
<td>-0.083*</td>
<td>-0.025</td>
<td>0.001</td>
<td>-0.012</td>
<td>-0.038</td>
<td>-0.024</td>
<td>-0.096**</td>
<td>0.387***</td>
<td>0.356***</td>
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</tr>
<tr>
<td>11. Identity Salience</td>
<td>-0.105**</td>
<td>-0.087*</td>
<td>-0.106**</td>
<td>0.169***</td>
<td>-0.03</td>
<td>0.011</td>
<td>0.031</td>
<td>0.241***</td>
<td>0.171***</td>
<td>0.262***</td>
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</tr>
<tr>
<td>12. Positive Emotions</td>
<td>-0.055</td>
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<td>0.049</td>
<td>-0.053</td>
<td>-0.047</td>
<td>0.069</td>
<td>-0.11**</td>
<td>0.338***</td>
<td>0.085*</td>
<td>0.298***</td>
<td>0.121**</td>
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<td>13. Negative Emotions</td>
<td>0.037</td>
<td>-0.024</td>
<td>0.127***</td>
<td>0.100**</td>
<td>0.049</td>
<td>-0.087*</td>
<td>0.182***</td>
<td>-0.219***</td>
<td>0.043</td>
<td>-0.094**</td>
<td>0.035</td>
<td>-0.408***</td>
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<td>14. Agitated</td>
<td>-0.033</td>
<td>-0.2</td>
<td>-0.107**</td>
<td>0.11**</td>
<td>0.056</td>
<td>-0.076*</td>
<td>0.181***</td>
<td>-0.252***</td>
<td>0.028</td>
<td>-0.063</td>
<td>0.075*</td>
<td>-0.435***</td>
<td>0.561***</td>
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</table>

*p < .05; **p < .01; ***p < .001
Table 3. Regression of **Positive** Emotions on Demographic Characteristics, Job Characteristics, and Identity Discrepancy (N = 775)

<table>
<thead>
<tr>
<th>Demographic Characteristics</th>
<th>b</th>
<th>SE</th>
<th>β</th>
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<tbody>
<tr>
<td>RNs of Color</td>
<td>-.563</td>
<td>.498</td>
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<tr>
<td>Male Nurses</td>
<td>1.278</td>
<td>.560</td>
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<tr>
<td>Years as RN</td>
<td>.019</td>
<td>.014</td>
<td>.047</td>
</tr>
<tr>
<td>Education</td>
<td>.029</td>
<td>.242</td>
<td>.004</td>
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<table>
<thead>
<tr>
<th>Job Characteristics</th>
<th>b</th>
<th>SE</th>
<th>β</th>
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</thead>
<tbody>
<tr>
<td>Patient Load</td>
<td>.008</td>
<td>.011</td>
<td>.024</td>
</tr>
<tr>
<td>Percentage of time spent with patients</td>
<td>.009</td>
<td>.006</td>
<td>.048</td>
</tr>
<tr>
<td>Perceived Workload</td>
<td>-.713</td>
<td>.060</td>
<td>-.395***</td>
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</table>

RN-Patient Identity Discrepancy

| Constant                    | 22.647 |
| R²                          | .182   |
| Adjusted R²                 | .174   |

†p < .10; *p < .05; **p < .01; ***p < .001
Table 4. Regression of **Negative** Emotions on Demographic Characteristics, Job Characteristics, and Identity Discrepancy (N = 775)

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>SE</th>
<th>β</th>
</tr>
</thead>
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<tr>
<td><strong>Demographic Characteristics</strong></td>
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<tr>
<td>RNs of Color</td>
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</tr>
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<td>Years as RN</td>
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<td>.028</td>
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<td><strong>Job Characteristics</strong></td>
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</tr>
<tr>
<td>Patient Load</td>
<td>-.002</td>
<td>.010</td>
<td>-.007</td>
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<td>Percentage of time spent with patients</td>
<td>-.012</td>
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<tr>
<td>Perceived Workload</td>
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<td><strong>RN-Patient Identity Discrepancy</strong></td>
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<tr>
<td>Constant</td>
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<tr>
<td>Adjusted R²</td>
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†p < .10; *p < .05; **p < .01; ***p < .001
Table 5.1. Regression of Agitated Emotions on Demographic Characteristics, Job Characteristics, Identity Discrepancy ($N = 775$)

<table>
<thead>
<tr>
<th></th>
<th>$b$</th>
<th>$SE$</th>
<th>$\beta$</th>
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<td><strong>Demographic Characteristics</strong></td>
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<tr>
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<td>Male Nurses</td>
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<td>Years as RN</td>
<td>-.033</td>
<td>.010</td>
<td>-.103***</td>
</tr>
<tr>
<td>Education</td>
<td>.210</td>
<td>.178</td>
<td>.037</td>
</tr>
<tr>
<td><strong>Job Characteristics</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Patient Load</td>
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<td>.008</td>
<td>.026</td>
</tr>
<tr>
<td>Percentage of time spent with patients</td>
<td>-.008</td>
<td>.005</td>
<td>-.053†</td>
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<tr>
<td>Perceived Workload</td>
<td>.643</td>
<td>.044</td>
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<td><strong>RN-Patient Identity Discrepancy</strong></td>
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<td>Discrepancy</td>
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<td>.158***</td>
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<tr>
<td><strong>Constant</strong></td>
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</tr>
<tr>
<td>$R^2$</td>
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<tr>
<td>Adjusted $R^2$</td>
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†p<.10; *p < .05; **p < .01; ***p < .001
Table 5.2. Regression of Agitated Emotions on Demographic Characteristics, Job Characteristics, and Identity Discrepancy X Intensive Commitment (N = 775)

<table>
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<tr>
<td>Years as RN</td>
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</tr>
<tr>
<td>Education</td>
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<td>.038</td>
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<table>
<thead>
<tr>
<th>Job Characteristics</th>
<th></th>
<th></th>
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</thead>
<tbody>
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<td>.008</td>
<td>.030</td>
</tr>
<tr>
<td>Percentage of time spent with patients</td>
<td>-.008</td>
<td>.005</td>
<td>-.051</td>
</tr>
<tr>
<td>Perceived Workload</td>
<td>.644</td>
<td>.044</td>
<td>.460***</td>
</tr>
</tbody>
</table>

| RN-Patient Identity Discrepancy                  | .572   | .189| .367**     |

| Intensive Commitment                             | .097   | .060| .077       |

| Intensive Commitment X RN-Patient Identity       | -.028  | .016| -.225†     |

| Constant                                         | -2.403 |     |            |
| \(R^2\)                                          | .270   |     |            |
| Adjusted \(R^2\)                                 | .260   |     |            |

\(†p< .10; *p < .05; **p < .01; ***p < .001\)
Figure 1. Interaction of RN-Patient Identity Discrepancy and Intensive Commitment on the Experience of Agitated Emotions