Belongingness: Malaysian Nurses' Experiences in the Clinical Workplace

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Abstract

The need to belong has been proposed to be the most basic need for human psychological wellbeing. Lack of belongingness has been associated with stress, anxiety, and lack of esteem. Understanding the nature of nurses' interconnection with others and their perceptions of belongingness has been linked to social and psychological functioning in the workplace. The purpose of this mixed-methods study was to explore factors contributing to Malaysian nurses' sense of belonging in the workplace. Registered nurses (n = 437) from two hospitals in Kuala Lumpur, Malaysia, completed a previously validated questionnaires translated into the Malay language. Questionnaires were analysed using a variety of statistical measures for the close-ended questions, and content analysis for two open-ended questions. Subsequent to answering the survey, ten nurses participated in individual interviews which were thematically analysed. Nurses enhanced their sense of belonging through acceptance, 'fitting in', respect, and group harmony. There were no specific demographic factors contributing to the perceptions. The four core themes that emerged from the interview were: what it means to belong; being heard; finding a way to fit in; and the influence of Malay culture. The findings confirmed the positive effects of sense of belonging on feeling motivated, confidence level, and job satisfaction. The results also provide evidence for an effect of positive workplace culture which included supportive colleagues, the nursing manager and the other health care team members in enhancing a sense of belonging among nurses. Aspects of belongingness in Malaysian nurses reflect those of nurses elsewhere. However, there are specific cultural influences at play. Given the likely influence of Malaysian culture, development of a measurement scale based on Eastern culture would help in enhancing understanding of workplace practices among these groups of nurses.

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Declaration

This thesis does not contain any material which has been accepted for the award of any other degree or diploma in any university and that, to the best of candidate's knowledge and belief, the thesis contains no material previously published or written by another person except when due reference is made in the text of the thesis.

Signed: ……

Date: ……

Ethics approval for this research was granted by the Standing Committee on Ethics in Research Involving Humans from Monash University on 19 May, 2011; Project number: CF11/1379 – 2011000763.

Ethics approval was also granted by the Ministry of Health Malaysia Ethics Committee on the 24 June, 2011; Project number: NMRR-11-223-8561, and the University Kebangsaan Malaysia Research and Committee on the 18 July 2011; Project number: FF-282-2011.

Dedication

I dedicate this work to my husband Zanudian for supporting me through this journey. Whenever I faltered, you were there to encourage, and never lose faith that I could do it. I love you for giving me the space and time required to complete this thesis. I also dedicate this dissertation to my daughter Saffiyah who has always been my inspiration, who always tried her best to be patient and understand when mom had to work on school holidays and during her sick days, and my parents Tugiam and Mohamed, who patiently waited for my return.

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Chapter One: Introduction

1.1 Overview of the chapter

One pervasive human concern is establishing and maintaining relatedness to others. A sense of belonging has been identified as one specific process of developing relationships with others which promotes better social well-being (Hagerty, Lynch-Sauer, Patusky, Bouwsema, & Collier, 1992). The need to develop meaningful interpersonal relationships and feel a sense of belonging in a relationship is important, as people will survive, develop, and grow within this process (Hagerty, Williams, Coyne, & Early, 1996). Therefore, understanding the nature of people's interconnection with others in the working environment and their perceptions of those relationships is believed to assist in social and psychological functioning in the workplace. This thesis reflects on the sense of belonging and intrinsic motivation that influences nurses' actions and behaviour in the workplace, exploring the context of belongingness in the workplace within the context of nursing in Malaysia. In this introductory chapter, an overview of the research background and issues that underpinned this research interest are briefly discussed, and the term 'belongingness' in the context of this study is defined. Next, the research aims and questions of the study are presented. Finally, the significance of the research is outlined.

1.2 Background to the study

The motivation to undertake the current study came from my own nursing experiences in Malaysia, during which time the value of nursing care was only moderately recognised by others, and nurses were seldom included in the organisation's decision-making processes. Through my personal experience of being involved in the nursing profession for more than twenty years in Malaysia, I have seen nurses struggle to bring their own profession to a level accepted by other health care team members and even by patients, relatives, and communities.

More often, nurses have been criticised in public media for negligence, poor communication and nursing care (Utusan Malaysia, 2000, 2010). Nurses have been named as culprits, even though there may not have been a nurse working in the particular area (e.g. in the pharmacy). These problems might occur due to negative stereotypical thinking about Malaysian nurses' abilities or knowledge by the community, or lack of communication or explanations from nurses themselves to patients or relatives.

This study was also triggered by my Master's research where levels of confidence among Malaysian nurses were found to be low. This situation happened regardless of whether nurses had worked in the same place for more than five years or had a six-month post-basic nursing certificate (for example, Neonatal Nursing Care Certificate), which suggests they had greater knowledge of specific nursing care of patients in a specialised area (for example, neonatal patients). According to Benner (1984) in her model of skill acquisition, nurses who have worked with similar patient populations for more than approximately five years should have reached the expert level of performance, and hence have increased levels of confidence. In terms of knowledge, education has been associated with increased levels of confidence (Ngo & Murphy, 2005). Thus, what actually influences Malaysian nurses' levels of confidence was of interest to me.

It has been emphasised that nurses in Malaysia not only need knowledge in nursing, but also knowledge in interpersonal relationships such as communication, decision making and problem solving to enhance their confidence (Nafsiah, 2002). Nafsiah (2002) further stated that even though nursing in Malaysia stands within a medically-controlled health care system, nurses need to be active participants in the care of patients and know the activities in the care of patients who are under their care. Mohamed, Newton and Lau (2013) found that nurses in Malaysia did not have enough confidence and courage to speak. They became silent knowers

even though they had extra knowledge to share. This finding is supported by the work of Daiski (2004) who also found that nurses often remained silent even when they were given opportunities to represent a patient's wishes. The concept of 'silent knower' will be discussed further in Chapter Three.

Nursing in Malaysia has still maintained most of its traditional values in the workplace. According to the Department of Higher Education (2010), the nursing services have not gained much in terms of autonomy and empowerment. The nursing practice is task oriented, based almost solely on doctors' orders, and leadership remains subservient to the medical profession. For example, the Nursing Board of Malaysia had been chaired by a medical doctor for the previous sixty years. Unlike other countries in the neighbourhood, such as Thailand, the nursing board changed to a nursing council chaired by a nurse since 1986 (Department of Higher Education, 2010). It raises the question of why the nursing profession in Malaysia has not yet developed, despite Malaysia being a rapidly developing country. Even though much research has been undertaken and acted on in the Malaysian nursing context (Nora & Oranye, 2010; Muhammad & Jamilha, 2010), progression is considered slow compared to other countries in the neighbourhood. The reasons for the situation remain unclear.

One important aid to understanding is an exploration of Malaysian nurses' sense of belonging. Sense of belonging is an important aspect of the current study because of its relationship to achieving success and self-esteem. It has been proposed as an influence on the interpersonal relationships of an individual. An individual's sense of belonging in an environment is dependent on the strength of relationships within that environment (Winter-Collins & McDaniel, 2000). Winter-Collins and McDaniel (2000) further contend that understanding the nature of people's interconnection with others in their working environments, and their perceptions of those relationships, will help the social and psychological functioning in the

workplace. Even though sense of belonging appears to be one important element in developing and managing one's relationships with others (Hagerty et al., 1996), it has, however, received little attention in the context of the Malaysian nursing workforce. There are many factors contributing to and influencing a sense of belonging in the workplace. Internal factors pertaining to the workers themselves (Ashkanasy, Hartel, & Zerbe, 2000), external factors from the surroundings (Avey, Avolio, Crossley, & Luthans, 2009), and the actual workplace culture (Ryan & Deci, 2000) have been cited as playing a role. As this study was conducted with nurses in Malaysia, it was also important to consider the cultural factors that may have had an impact.

1.2.1 Malay culture in the context of this study

Culture has been defined as a "set of behaviour patterns related to thoughts, manners and actions, which members of society have shared and passed on to succeeding generations" Mansor (2010, p. 28). Mansor (2010) further contends that culture reflects a shared general belief which describes the 'should' and the 'ought to' of life for members in the society. These include religion, heritage, language and values that derive from the fundamental assumptions and beliefs of its members. Therefore, culture distinguishes the members of one group of people from another. Malaysia is a pluralistic and multicultural nation. There are several ethnic groups that include Malay (the main ethnic group), Chinese, Indian, and Malaysia's indigenous people. The indigenous people are known as 'orang asli', a Malay term which translates as 'original people' or 'first people'. There are several groups of 'orang asli' ethnicity scattered around Malaysia. According to the Department of Statistics Malaysia (2011), out of the total population of 28.3 million people, 67.4% identified as Malay, 24.6% as Chinese, 7.3% as Indians, and 0.7% as other Malaysian indigenous people from more than 200 different ethnicities. Each community has its own identity, beliefs, and traditions (Mansor, 2010; Singh, Dilnutt, & Lakomski, 2008).

Malaysian values are deep-rooted and differ from some Western values (Mansor, 2010). Common shared values that bring Malaysians together are respect for superiors and elders, emphasis on belonging to a group (Jamal, 2006), harmonious relationships, concern for others, 'face saving', and religious orientation (Abdullah, 2001; Asma, 1996). Politeness is used to deal with disagreements when a conflicting view is presented and discussed (Paramasivam, 2007). Mastor, Jin and Cooper (2000) further stated that Malaysians place great emphasis on manners, politeness, consideration of others, and courteousness. Their verbal expressions may not necessarily reflect their real feelings or opinions and they may be direct or indirect, depending on the situation and the person (Mastor et al., 2000). For example, to claim oneself to be more competent than others is rare in Malay culture although the speaker may really be so. Furthermore, Malay people are raised and expected to behave according to the rule of *budi.* Generosity, respect, sincerity, righteousness, consideration, caring, discretion, and feelings of shame are virtuous qualities of *budi*. In the rule of *budi*, a person must be aware of his/her position within society and behave according to that position (Dahlan, 1991). People who are from lower positions are forced to conceal their unhappiness in the workplace. Dahlan (1991) explained:

> …the *budi* thinking man is never direct and forthright in his ways: his ways are subtle…to be blunt, direct and forthright especially if the end result is negative… is considered rude and out of tune in the Malay polite system… hence a *budi* thinking man is by nature polite and conflict-avoiding (pp.12-13).

In the Malaysian workforce, Abdullah (1994) identified that the common culturally-based value orientation includes: 1) collectivism which is performance orientation, teamwork, cooperation, strong sense of belonging, priority to group interest, and satisfaction which is derived from respect from colleagues; 2) respect for hierarchy and senior or elderly people

which is social formality. An individual will not argue with the boss and is reluctant to ask for help or check for understanding; 3) respect for loyalty and authority which is to act with deference and obedience; 4) preserving face which is trying to avoid loss of face and self-esteem, avoiding public criticism, being uncomfortable in critically evaluating peers and subordinates or giving negative feedback; and 5) liking to work in harmony by trying to compromise with others and preferring non-confrontational behaviour. Niven (2000) further explained that in the Malaysian workforce, authority involves issuing commands, rather than requests and modelling. Therefore, it is of value to investigate if the Malaysian common culturally based value orientation also persists in the Malaysian nursing workforce.

1.2.2 Organisational culture and the interplay on respect

Organisational culture refers to the nature of perceptions of values, beliefs, and behaviours of organisation members (Malloy et al., 2009). Specifically, it refers to the informal, yet collective, perceptions and behaviours concerning what are ethically acceptable or unacceptable within the context of an organisation (Malloy & Agarwal, 2003). Gershon et al. (2007) described organisational culture as how individuals perceive each other's professions, their jurisdiction, and status in the hierarchy. It is understood to be "the way things actually are" (Malloy et al., 2009, p. 726). The most influential organisational culture in nursing includes poor relationships with physicians, and difficulty in gaining professional respect (Gershon et al., 2007). Liden and Maslyn (1998) defined professional respect as perception of the degree to which each member of the dyad had built a reputation, within and/or outside the organisation, of excelling at his or her line of work. A recent government report in nursing organisation, nursing organisation in Malaysia is typically bound to the traditional culture of hierarchical power in which people in authority in nursing organisations and senior nurses with more experience 'deserve respect' from nursing subordinates (Department of Higher Education, 2010). While respect for hierarchical power and seniority might have a significant

role in the nursing profession; this tradition potentially leads to stereotypical misperceptions of nursing as a weak and second class-profession (Kelly, Fealy, & Watson, 2011).

1.2.3 Stereotypical views of nursing

The public often have stereotypical views of the nursing profession. Fletcher (2007) argues that stereotypical views are based on people's perceptions, for example, nurses as doctors' hand maidens, and nursing as a profession that requires little knowledge as nurses' actions are based on doctors' orders. Ierardi, Fitzgerald, and Holland (2010) stated that the nursing profession is strongly influenced by societal stereotypes and images, and by the predominance of female role models, due to historical and cultural reasons. In Malaysia, the nursing workforce is composed almost exclusively of women. The percentage of male nurses is still low, even though the numbers of male nursing students in Malaysian nursing colleges has increased. Until June 2012, the Malaysian Nursing Board reported there were only 647 males (about 1%) out of 62,527 practising nurses in Malaysian hospitals (S. Safiah, personal communication, August 29, 2012).

Researchers claim that the stereotypical public image of nursing could constrain nursing practice and have the ability to jeopardise nurses' sense of belonging by: i) distorting the public's concept of nursing, ii) depriving the public of knowledge of nurses' services, iii) affecting the quality and number of people who enter nursing, iv) affecting the decisions of policymakers, v) affecting nurses' self-image by undermining self-confidence, beliefs and values, and vi) influencing the development of poor collective self-esteem, job satisfaction and performance (Kalisch, Begneny, & Newman, 2007; Kelly, Fealy, & Watson, 2011; Takase, 2005). Within the nursing workplace culture, subservience is perpetuated by the public images of nursing. Until the 1920s, nurses were identified as 'ministering angels' (Hoel, Giga, & Davidson, 2007). The nursing profession appears to have been at a high point

in status between the years 1930 and 1940 where nurses were depicted in responsible and autonomous roles (McKenna & Newton, 2008). However, from the 1960s, nurses started to be portrayed as subservient and taking orders (Billett, 2006).

The perception of nursing as sitting in a lowly position in the medical hierarchy gives nursing little opportunity to demonstrate professional autonomy. Mathes (2004) and Andersson and Edberg (2010) argue that when nurses rely more on authority from administrators and doctors, they gain less respect and are perceived to have lack of confidence in their professional abilities. Andersson and Edberg (2010) further contended that when nurses felt that they were respected by others, it provided confirmation that they belonged to the hierarchy. It also implies that they were seen as competent and capable by others, including patients and relatives (Andersson & Edberg, 2010). This situation is important for nurses, particularly in Malaysia, because they need to be involved in discussions with other disciplines regarding their patients' progress.

1.2.4 Nursing in Malaysia

Globally, the practice of nursing varies little in terms of the role of the nurse. However, there is variation in the image and status of nursing as a profession, often in response to sociocultural factors that influence how nursing is perceived in any given country. Substantial progress has been made in advancing the status of nursing. According to Birks, Chapman and Francis (2009), significant advancements in the nursing profession occurred during the final decades of the twentieth century and are most evident in the Western world. Nursing in Malaysia earns its heritage from the British. While British nursing has evolved with time, the traditional British system is still present in the Malaysian workforce (Department of Higher Education, 2010), and nursing in Malaysia is still developing (Nafsiah, 2002). According to the Department of Higher Education (2010), the nursing profession still struggles with a

number of factors (for example, hierarchical values, stereotypical perceptions of nursing as a female job, subordinate or assistant of the medical officer, traditions of Malaysian culture) that impede its quest for recognition as an autonomous, independent profession. Leadership remains subservient to the medical profession either because it provides stability or is influenced by other factors such as obedience and respect (Department of Higher Education, 2010). Birks et al. (2009) studied nursing status in Malaysia and suggest that nursing in Malaysia still remains an oppressed profession.

Using a five-stage model that was originally proposed by Roberts (2000) to explain processes through which nurses evolve in rising above oppression, Birks et al. (2009) examined the extent to which nurses in Malaysia were an oppressed group. The five-stage model was composed of i) unexamined acceptance – represents ignorance by nurses of their oppressed status, ii) awareness – nurses are awakened to their oppression, iii) connection – nurses seek support from others to share their emerging perspective, iv) synthesis – of the new image occurs as the nurse internalises the empowered self, and v) political action – the nurse becomes committed to change for both nursing and the broader social environment (Roberts, 2000). According to Birks et al. (2009), nurses in Malaysia can be located in the first phase; that is, a role characterised by unquestioning acceptance of the role of nurses, the power of the system, and dominance of physicians and people in authority. Birks et al. (2009) argue that there is "no doubt that some nurses in Malaysia have moved beyond the first step in recognising and attempting to mitigate factors that negatively affect the profession" (p. 121). Advanced nurses, however, are a minority when compared to the grand total of Malaysian nurses, thus limiting their voices from being heard (Birks et al., 2009).

Nursing shortage is a universal problem. Arif, Omar, and Yon (2003) and Ministry of Health Malaysia (2008) reported that hospital staffing levels, including nursing staff, were

inadequate to provide safe and effective care. Even though there has been an increase in the number of nurses from 47,642 in 2006 to 62,527 in 2012 with a subsequent improvement in the nurse-to-population ratio from 1:559 to 1:325 (S. Safiah, personal communication, August 29, 2012), the goal is to reach a ratio of one nurse to every 200 people by 2020 (1:200) based on the standards set by the World Health Organisation (WHO) (Department of Higher Education, 2010). Several measures can be taken to combat workforce shortages. These include: i) increasing supply by increasing more nursing graduates or by active recruitment of nurses from other countries, ii) reducing demand by restructuring the workforce (strengthening and improving primary health care reduced health demand by lowering hospitalisation rate, fewer health inequalities and better health outcomes (Australian Government, Department of Health and Ageing, 2009), iii) decreasing beds in hospitals, and/or iv) improving the retention of nurses by improving the working environment and providing support to nurses (Jasper, 2007; Kingma, 2007).

In response to nursing shortages, the Malaysian authorities chose to increase nursing supply which included increasing the number of public and private institutions providing nursing courses, increasing the total number of nursing intakes (Barnett, Namasivayam, & Narudin, 2010), and recruiting nurses internationally (Tee, 2006). In 2008, there were seventeen public nursing colleges, ten public universities offering nursing programmes and fifty-four private nursing colleges. Together, they produced 6,000 diploma graduates – 2,500 from the Ministry of Health and 3,500 from private colleges (Bernama, 2010). Six months later in 2009, the number of private colleges had increased to seventy, which is sixteen more, in a matter of months. The number of graduates doubled. Out of ninety-seven nursing colleges, eighty-eight offer diploma programmes (Department of Higher Education, 2010). By December 2009, there were 83,302 nurses in the country (Bernama, 2010).

For many years, the production of nurses has become a competitive venture. The more nursing shortages are encountered, the more business can be made. As schools and colleges compete for the same pool of nursing students, some concerns have been expressed that entry standards may fall as nursing colleges start to increase their student intakes, with lower qualifications required (Department of Higher Education, 2010). In 2010, 415 nursing graduates were produced by public universities, while the other 1,760 nursing graduates were produced by private nursing colleges (Bernama, 2010). The Department of Higher Education (2010) and Barnett et al. (2010) argue that this dramatic expansion would pose a threat to the long-term stability of the nursing workforce, impact on the quality of nursing care delivered, and place extra burden on Malaysian nursing education. Should the quality of nurses produced be compromised, it would be more difficult for the nursing profession as a whole to gain respect (Barnett et al., 2010). This would further impede nurses' actions to achieve belongingness in the workplace.

Malaysian nursing education

In Malaysia, Registered Staff Nurses (RSNs) obtain their basic nursing qualification either through the Ministry of Health (hospital-based), Ministry of Higher Education (university-based) or private nursing schools run by private nursing colleges. Nursing students from private nursing colleges will have clinical experience at their own private hospitals. However, in private colleges that do not have their own private hospitals, nursing students have their clinical experiences at hospitals run either under the Ministry of Health or Ministry of Higher Education, depending on their individual Memorandum of Understanding (MOU) agreement. The Diploma in Nursing is the most basic nursing qualification in Malaysia which enables a new graduate to practise as a Registered Staff Nurse (Grade U29). Nurses are prepared by undertaking a three-year diploma-level qualification for basic nursing and an examination, run by the Ministry of Health, Ministry of Higher Education or private nursing college. It is

generally accepted that diploma nurses are task-oriented, obedient and passive, the result possibly of low entry requirements and teacher-centred, didactic approaches in education (Department of Higher Education, 2010).

The degree program in nursing was first introduced in 2000. Currently, there are two types of degree programs in nursing. The four-year course is offered to fresh candidates from the matriculation (final year of high school) program. A two-and-a-half year course is offered as an upgrade from diploma to degree qualifications for diploma-qualified nurses with at least three years' experience working as nurses. The degree courses are only run at nursing colleges under the Ministry of Higher Education or selected private nursing colleges. The educational entry requirements are different, with diploma programs accepting lower academic grades, the Sijil Pelajaran Malaysia (SPM, i.e. successful completion of the penultimate year of secondary schooling), while entry to the degree program requires grades from matriculation, or the Sijil Tinggi Pelajaran Malaysia (STPM, i.e. successful completion of the final year of secondary schooling). Methods of teaching and learning depend on each nursing college's best approach to delivering the nursing theoretical content and to producing the best nursing candidates.

At the end of the three- or four-year basic nursing program, all graduates sit for a compulsory Malaysian Nursing Board examination and must pass the examination according to the Board standard (H. Hamidah, personal communication, 27 March, 2013). If they are trained at any institution other than a nursing college run by the Ministry of Health, candidates are required to sit and pass the university or the private college's own examination paper and later sit the Malaysian Nursing Board exam. This means that these nursing students are expected to sit and pass two different sets of examinations to enable them to practise as Registered Staff Nurses in Malaysia. New graduates with degree qualifications will practise as Registered

Staff Nurses (Grade U41), a position which offers better salary with the same work descriptions as Registered Staff Nurse with diploma qualifications (Grade U29). However, there are limited positions available to practise as Registered Staff Nurses (Grade U41), with some new graduates with degree qualifications needing to practise at diploma qualification level Registered Staff Nurses (Grade U29).

Clinical placement experience provides nursing students with the opportunity to apply the theory and skills that they learn in the classroom to a real scenario with real patients. In Malaysia, the nursing training programmes offer nursing students 50% academic learning and 50% clinical learning. The clinical placement is based on immediate application of theory into practice, which means the clinical placements for the semester will follow once the academic learning for that semester is finished. The length and time of nursing students' posting in the clinical area follows the normal shift duty of staff nurses, which is seven hours for morning shift (7 a.m. to 2 p.m.), seven hours for afternoon shift (2 p.m. to 9 p.m.), and ten hours for night shift (9 p.m. to 7a.m.). Students have a variety of clinical placements in hospitals, clinics, and within patients' homes. One Clinical Instructor will be allocated at the clinical placement site to guide nursing students during their clinical placements. However, the Clinical Instructors are limited, and often they cannot cover every single site of students' placement. Therefore, there are nursing preceptors appointed in most of the wards. These nursing preceptors are subject to normal ward shift duties and, therefore, the nursing preceptors are not always available in the ward during students' posting. Even if the nursing preceptor is available, she/he is also responsible for his/her normal shift duty as a Registered Staff Nurse in the ward. In other words, even though there is a Clinical Instructor or nursing preceptor in the ward, they are not necessarily available on each single posting of the nursing students, or, if they are available, they cannot concentrate on supervising nursing students for

the entire seven or ten hours of posting. This lack of concentration may impact on nursing students' clinical support, hence jeopardising their sense of belonging.

1.3 Definition of belongingness

Belongingness has been defined from various viewpoints in social sciences and psychology. Anant (1967) described belongingness as recognition and acceptance of a member by other members in a group. Maslow (1987) explained belongingness as the human need to be accepted, recognised, valued and appreciated by a group of other people. He proposed five levels of needs in human life starting from basic needs to esteem needs at the top of the hierarchy. The third level, meeting love and belongingness, follows the necessity of attaining basic physical and security requirements before belongingness is achieved. Maslow's theory of human needs will be discussed further in Chapter Two.

Being involved with group activities has been suggested as one important element in defining belongingness. According to Hagerty et al. (1992), sense of belonging is the experience of personal involvement in a social system or environment so that individuals feel themselves to be an integral part of that system (relationship or organisation) or environment (natural or cultural). Somers (1999, pp. 16-17) defined belongingness as:

> the need to be and perception of being involved with others at differing interpersonal level across varying environments which contributes to one's sense of connectedness (being part of, feeling accepted, and fitting in), and esteem (being cared about, valued and respected by others).

In the Oxford Advanced Learner's Dictionary, Hornby and Turnbull (2010) defined 'belonging' as being part of a particular group type, or system and to feel comfortable and happy in a particular situation or with a particular group of people.

A recent definition of belongingness in social sciences is by Levett-Jones and Lathlean (2009a). Generated from nursing students' experiences in the clinical placement, Levett-Jones and Lathlean (p. 2872) defined belongingness as:

> A deeply personal and contextually mediated experience that evolves in response to the degree to which an individual feels (a) secure, accepted, included, valued and respected by a defined group, (b) connected with or integral to the group, and (c) that their professional and/or personal values are in harmony with those of the group.

For the purpose of this study, the definition by Levett-Jones and Lathlean (2009a) has been used because the definition is more comprehensive and reflects the current study context.

1.4 Significance of the study

Considerable research has been conducted to improve knowledge and levels of confidence among graduated nurses including educational interventions, and application of guidelines on nursing procedures and ward routine (Bowling, 2011; Cook et al., 2013; Shipman et al., 2008). Subsequent to educational interventions and implementing guidelines, a follow-up study of the same group of nurses (after six months) showed increased knowledge and confidence levels were still significant among nurses (Shipman et al., 2008). The findings suggest that the influence of support and attention given during the education intervention and while implementing guidelines helps to improve nurses' knowledge, actions, and behaviour. However, increased levels of confidence and use of implemented guidelines were not sustained for a longer time. Complicated nurse-physician relationships, nurses' resistance to change, and influence from nursing management and the health care organisation have been cited as common obstacles in implementing change in the clinical area (Simpson & Doig, 2007).

Sense of belonging has been found to influence nurses' actions and behaviour in the workplace (Levett-Jones, 2007; Paton, 2010). Available research on belongingness primarily relates to nursing education, rather than nursing practice. What is lacking in existing descriptions of belongingness is registered nurses' perspectives, an understanding derived from nurses' experiences and practice on how to create support in the clinical workplace, and thus increase the nurse's sense of belonging. The intent of the current study was to understand the concept of belongingness from the nurses' perspectives, and to investigate how the information gained could assist in creating supportive workplace settings, leading to increased motivation and confidence levels, hence increased job satisfaction. Creating supportive work settings might also prevent premature exodus from the profession and positively dissuade experienced nurses from leaving nursing practice (Paton, 2010). The findings might benefit not only the Malaysian setting, but also nurse administrators and managers internationally to better understand the concept of belongingness for graduate nurses in the workplace. As the current study is the first study exploring the belongingness concept among staff nurses in Malaysia, the findings will contribute to: 1) enhancing our understanding of what nurses value in their workplace; and 2) finding ways to assist nurses to feel a sense of belonging to their workplace. The study is particularly unique in that it fills a void in knowledge about Malaysian nursing. By adding this body of knowledge, hopefully it will help in retaining graduate nurses in clinical areas through the development of appropriate professional development and continuing education programs.

1.5 Aims of the Study

This study aimed to explore intrinsic and extrinsic factors that contributed to Malaysian nurses' sense of belonging in the clinical workplace. In doing so, it sought to address the following research questions:

1) To what extent do nurses experience the concept of belongingness in the workplace with colleagues, other health care team members, and the organisation?

2) Is there a relationship between nurses' experiences of belongingness in the workplace with their intrinsic motivation, feeling of confidence, and job satisfaction?

3) What strategies do nurses use to fit in with colleagues and other health care team members?

In order to seek answers to the research questions and understand the concept of belongingness among Malaysian nurses, a mixed-methods approach with two different hospitals was chosen. For the purpose of this study, a quantitative approach with survey design and a qualitative approach with face-to-face semi-structured interviews were employed. Registered staff nurses at two hospitals involved in delivering direct patient care were invited to participate in the study as they could provide rich data derived from their experience in the workplace.

1.6 Thesis construction

This chapter has introduced the concept of belongingness and contextualised the cultural setting of the study. To understand the meaning of belongingness, definitions from the literature have been presented. The author's observation and personal experiences provided background to the study. The significance of the study has been explained, the research questions posed, and the mixed-methods design introduced. Chapters Two and Three provide a detailed review of the literature and theoretical foundations of sense of belonging and belongingness. While the literature in Chapter Two provides a range of studies from the fields of psychology, mental health and education, Chapter Three is more specific to nursing practice. Reviews of nursing literature suggest there is a gap in exploring more experienced nurses' sense of belonging. Most of the available belongingness studies focus more on nursing students' and newly graduated nurses' experiences.

In Chapter Four, the research design and methodology of the research approach that guided the study are presented. The selection of pragmatism as the conceptual framework is justified at the beginning of the chapter. An outline of the mixed-methods approach is provided. The outline is divided into two sections: the quantitative and the qualitative phase. The chapter provides an explanation of research participants, the instruments, data collection methods, and the tests used for statistical analysis, content and thematic analysis. Ethical issues are also discussed in this chapter. Chapter Five presents results from the quantitative survey, using a questionnaire to collect data. The chapter begins with demographic data of the respondents and continues with the results from each statistical procedure to provide answers to the research questions. Finally, content analysis from the open-ended questions provides answers regarding strategies nurses used to 'fit in' in the clinical workplace.

Results from the qualitative interviews are presented in Chapter Six. Thematic analysis was used to unfold the stories told by the participants. Quotes from the transcripts enhance the credibility of the findings. A detailed discussion of the findings from the quantitative and qualitative data analysis is offered in Chapter Seven. The chapter is structured around each of the three research questions, informed by the findings from the quantitative and, where appropriate, qualitative data and related literature. Some limitations of the study are also discussed in Chapter Seven. Chapter Eight, focuses on the relevance of the research findings and provides recommendations. The chapters conclude with personal reflections on the study.

1.7 Conclusion

This chapter has introduced the study and provided some context of the Malaysian culture in the nursing profession. The definition of belongingness and background to the study has been

provided to enhance the significance of this study, followed by a brief introduction of the mixed-methods approach to the study and overview of the thesis. The following chapter provides a comprehensive review of the literature surrounding belongingness in the fields of psychology, social science, and education.

Chapter Two: Belongingness in Psychology and Social Sciences

2.1 Introduction

Belongingness has received significant attention in the disciplines of psychology and social science. Much research has been performed to investigate the role and function of belongingness in human needs. This chapter provides a detailed analysis of the concept of belongingness. In doing so, it explores literature on belongingness from psychology, social science, and education. The belongingness literature related to nursing will be presented in Chapter Three. An extensive literature search was conducted using the keywords: belongingness, belonging, sense of belonging, fit, and acceptance. The search was performed using databases including PsycINFO, CINAHL, and MEDLINE for psychology and psychiatric literature, ERIC, A+ education, and Proquest for literature in education. Search engines, such as Google and Google Scholar, supplied other information related to belongingness and workplace, and assisted in narrowing the search to significant sources. Resources included journal articles, dissertations, and books.

2.2 Theoretical perspectives of belongingness

The founder of the human needs theory, Abraham Maslow, originally proposed five levels of needs in human life. Maslow (1943) created a visualisation of his hypothesis in the shape of a pyramid divided into five levels. At the bottom of the pyramid he placed the physiological level, considered the most basic needs for human survival, including food, water and shelter. Maslow (1943) contended that needs at the lower levels must be fulfilled before those needs at a higher level could emerge and have energy devoted to them. When the basic survival needs have been met, the individual moves to the next level and seeks safety. The third level is identified as the social level, which includes the need for belongingness, friendship and love. This is an important aspect as, if a person has failed to fulfil this level of needs, she or

he will never achieve the next level of satisfaction of esteem needs (Maslow, 1954) which results in lower prestige, self-confidence, power, and feelings of usefulness (Redman, 2010). Maslow's model has also been used in organisational settings, providing a means to understand employee motivation.

By the nature of human needs, one's main attention will be fully occupied at the level she/he has not satisfied. Benson and Dundis (2003) emphasised that it is important to note that all levels have a varying element of depth for the individual; what is adequate or necessary for one may be inadequate for another. Thus, the need to belong will be greater for one person than it will be for another because it deals with individual needs (Benson & Dundis, 2003). In terms of belongingness, Maslow (1954, p. 89) asserted that:

> If both the physiological and the safety needs are fairly well gratified, there will emerge the … belongingness needs… Now the person will hunger for affectionate relations with people in general, namely, for a place in his group, and he will strive with great intensity to achieve.

Having obtained relationship/belongingness security, it is then possible to look to the fourth level, self-esteem. In this area, the individual seeks to feel competent, confident, and self-assured. Finally, the individual having met the needs of the former four levels is able to pursue self-actualisation (Maslow, 1954).

It is important, however, to acknowledge that the five-step hierarchy of Maslow's theory has never been confirmed through research. The theory derives most directly from clinical experience (Maslow, 1954). Maslow is quoted as having said that his motivational theory must be considered to be a suggested program or framework for future research: "It should stand or fall, not so much on facts currently available or evidence presented, as upon research

yet to be done" (Maslow, 2000, p. 253). In another seminal work, Murphy (1954) proposed that a full understanding of human behaviour must begin from the root of human nature that underlies social and cultural behaviour. Murphy (1954) further stated that people are motivated to be accepted and supported by others. He noted that "in every society… there appears to be a considerable amount of satisfaction from sheer functioning as a member of a group" which reveals "the very strong positive satisfactions of discovering closeness with others" (Murphy, 1954, p. 620).

However, even though Murphy (1954) proposed his notion about belongingness, he did not make any strong argument to support his proposal. Despite continuing speculative assertions that people have a need to belong, Leary and Cox (2008) argued that the belongingness hypothesis needed critical evaluation in the light of observed evidence. This hypothesis should be viewed as "a fundamental social motive that underlies and helps to explain a great deal of human behaviour" (Leary & Cox, 2008, p.28). Although Maslow's theory has been criticised because it has never been confirmed through research, it provides a comprehensive basic foundation of human needs and has been quoted and referred to in many disciplines such as social science, health science, psychology, and education. Based on Maslow's theory, Baumeister and Leary (1995) emphasised that a need to belong is a fundamental human motivation and that human beings have a pervasive drive to form and maintain lasting, positive and significant relationships.

2.2.1 Belongingness – as a fundamental human motivation

According to Baumeister and Leary (1995), a fundamental motivation should: i) produce effects readily under all but adverse conditions, ii) have affective consequences, iii) direct cognitive processing, iv) when thwarted, lead to ill effects; for example, on health or

adjustment, v) elicit goal-oriented behaviour designed to satisfy it, vi) be universal in the sense of applying to all people, vii) not be derivative of other motives, viii) affect a broad variety of behaviours, and ix) have implications that go beyond immediate psychological functioning (p. 498). Baumeister and Leary (1995) found that existing evidence supported the hypothesis that the need to belong is a universal, strong, fundamental and extremely pervasive human motivation. Desire to belong comes naturally in every human, and when belongingness is successfully achieved, people become more willing to work in a collaborative and cooperative manner, an approach reflective of concern for others' wellbeing (De Cremer & Blader, 2006).

Once social bonds have been formed, people will feel reluctant to break them. Baumeister and Leary (1995) proposed that frequent positive interaction (which is free from conflict and negative effect) with other people is essential in social connectedness. In contrast, frequent contacts with non-supportive or indifferent people can only prevent one's general wellbeing and would do little to satisfy the need to belong. As a consequence, people would spend a lot of time processing and attempting to understand the phenomena when those relationships failed to fulfil their need to belong.

Being rejected by a group will increase sensitivity to social information. Gardner, Pickett, and Brewer (2000) undertook an experimental study consisting of ninety-one psychology students in a simulated chat room in America. Their study found that when there was an arousal of the need to belong (i.e. for the person who had been rejected before), memories of social information for a person were increased as they tried to make themselves accepted again in the group. Another experimental study conducted by Lakin (2003) on 169 female introductory psychology students in America, found that those who were rejected were also more sensitive to emotional vocal tone and were more accurate at detecting messages conveyed through

facial expression. These types of responses, according to Lakin (2003), are necessary as they will actually help the excluded person to avoid future rejection.

At the behavioural level, Baumeister and Leary (1995) identified that the absence of meaningful interpersonal relationships leads to an increase in behaviours such as unquestioning agreement with another person's decision. This can be seen in some people who maintain unsatisfying or unhappy relationships. From a review of abusive relationships between husbands and wives in America undertaken by Strube (1988), it was found that some women were unwilling to leave their abusive spouse even if they knew that the relationship might even cause more distress or harm. This phenomenon is supported by Baumeister, Twenge and Nuss (2002) who found that social exclusion will produce a short-term impairment in cognitive functioning and mediates reduction in intelligent thought. Thus, the belonging seeker will be in a state where he or she is willing to do what somebody wants and to accept their opinions, even though they are not sure whether they are right. Baumeister and Leary (1995) further concluded that the consequences of loss of belongingness may influence one's mental health which includes stress, depression, anxiety, maladjustment, decreased general wellbeing, and increased suicidal thought.

2.2.2 Belongingness and mental health

Being among the first to study the concept of belongingness and mental health, Anant (1967) argued that a need to belong had seldom been the subject of research, even though it had been recognised widely as an important human need. Emphasising the importance of belongingness in child development, school, social relationships and mental health, Anant (1969, p. 385) defined belongingness as "personal involvement (in a social system) to the extent that the person feels himself to be an indispensable and integral part of the system". Anant (1967) proposed two ways to reduce anxiety in terms of belongingness: 1) to have strong social ties

with people around you, especially in tough situations, and, secondly to be very knowledgeable, independent (in terms of ability to make your own decisions and accepts responsibility) and to be self-sufficient.

In order to support his notion, Anant (1967) explored the relationship between belongingness, anxiety and self-sufficiency on forty-seven nursing students from a general hospital in Canada. In this study, Anant proposed that when people are placed in strange situations, with lack of clarity about what to do, they are likely to become anxious. However, for the people who are an integral part of the social system, even though there may be no clear instructions about what to do, they feel more secure and less anxious. Anant (1967) further suggested that people who belong are more self-sufficient and capable of taking care of themselves. The results of this study supported an inverse relationship between belongingness and anxiety, and anxiety and self-sufficiency but did not support a positive relationship between belongingness and self-sufficiency.

Subsequently, Anant (1969) conducted another study to explore the relationships between belongingness, anxiety, and self-sufficiency. This time, the sample consisted of 138 college students from four traditional caste groups in India. The reason Anant conducted this study in India was because the people there are divided into different castes depending upon their wealth. People belonging to the same caste are bound together by strong ties, support each other financially and help each other in times of crisis. In India, when a person is able to study in college, he/she definitely comes from a higher or middle caste as they can afford to pay college fees and buy college needs such as books and stationery. People in the higher caste group, which is more stable financially and economically, are ostensibly free from anxiety and concerns about basic physiological needs. The same tests used previously in Canada in Anant (1967), Anant's Sense of Belongingness Questionnaire, Bernreuter's Self-Sufficiency

Scale and Willoughby's Personality Schedule, were used in this study (Anant, 1969). Anant's (1969) findings demonstrated that the mean belongingness score of the sample population was lower than that of the Canadian sample, and the mean self-sufficiency score was significantly high. Correlations between the three variables of belongingness, anxiety, and self-sufficiency were apparent, thus indicating a relationship between these three variables. Findings from this study support Anant's (1967) hypothesis that people who belong are more self-sufficient and less anxious. Even though Canada and India exhibit different social structures – India is more hierarchical while Canada has a more horizontal structure – these studies create beneficial comparisons between collectivist and individualist cultures. Results from both studies, however, should be treated with caution as Anant's studies were conducted in the 1960s and the instruments contained no information on validity and reliability measures.

It is evident that sense of belonging plays a role in influencing people's ways of thinking and behaviour. The interpersonal-psychological theory of suicidal behaviour (Joiner, 2005) proposed that the need to belong is so fundamental that, when it is met, it can prevent suicide. However, when the need to belong is thwarted, it will lead substantially to loneliness and depression and increases the risk for suicide. This proposal was supported by Orden et al. (2008) who studied 309 undergraduate students in one university in America. Orden et al. were interested to see whether suicidal ideation in college students varied across the university academic calendar. They found that students attending summer semester experienced higher levels of suicidal ideation when compared to other semesters. Even though Orden et al. found there was a relationship between social ideation and lack of belongingness, the cause of the relationship remains unclear as the study was based on a quantitative survey design only. In spite of drawing conclusions upon research findings, Orden et al. predicted that, during summer semester, students experienced lack of support and belongingness due to a long semester break with only a few students enrolled in this summer

semester. Such a prediction needs to be treated with caution as the causes of suicidal thoughts might vary among students of college age. However, the theory offers some ideas that belongingness is crucial in promoting social connectedness.

2.2.3 Belongingness and social connectedness

Every human belongs to numerous social groups, ranging from small groups such as families, schoolmates, course mates, or work teams, to larger groups of social categories, such as nations or ethnicities. There are no societies in which people do not form social connections with one another (Baumeister & Leary, 1995; Mann, 1980). Evidence from previous psychological studies has demonstrated that people quickly and easily develop group identification. This can be seen in the Classic Robber's Cave study conducted by Sherif, Harvey, White, Hood and Sherif (1961) in Oklahoma, America. The subjects of the experiment were twenty-two boys, aged 12, of middle-class socioeconomic standing, who had not experienced any unusual degree of frustration in their homes, nor school or social failures and had similar educational levels.

In Sherif et al.'s (1961) controversial study, the boys were divided into two groups. The major aim of the experiment was to see what perception of belonging to a group could do to the relationship of members within the group and to the people from the other group. During the first phase, both groups did not know the existence of the other group on the summer camp base. Each group spent time knowing each other, building their own identity, sharing the same values that regulate the behaviour and attitudes of the members, and gave a name to their group. By doing this, it granted the members belongingness and group spirit. Friction and stereotyping were then stimulated by a series of competitive activities with a reward for the members of the winning group. Frustration and accusation were seen in the losing group, and domination of place and power were shown by the winning group. Stereotypical attitudes

by the group members towards the other group members were observed. After the conflict and friction, the two groups were then stimulated to work and cooperate with each other, as efforts of a single group were inadequate to attain a solution to the problem. Cooperation was observed between the members of the two groups. It can be summarised that: 1) when individuals interact with one another with similar context and events, group structure will be formed and a sense of belonging increased; 2) during times of friction, uneasy conflicts and aggressive behaviour easily occurred. Stereotypical attitudes of group members towards opposition groups emerged and produced certain social distance; and 3) cooperation will occur when group members realise that efforts of one group are insufficient to achieve the desired goal.

Despite successful achievement in this experimental study, the sample was biased. The participants were limited to only one age group, one gender, one white ethnicity and one middle class socioeconomic status. Ethical issues in this study were compromised, as all participants were not informed regarding the aim of the study and they were not protected from physical and psychological harm. The participants came from middle-class socioeconomic backgrounds with well-adjusted manners; therefore their actions might not truly reflect real life situations. Therefore, the findings from Sherif et al.'s study are not generalisable to other groups or populations. Despite all the limitations, Sherif et al.'s (1961) findings have been linked to the realistic group conflict theory which explains how intergroup conflicts can arise as a result of conflicting goals and achievement. The findings are relevant to nursing and health care organisations as, by nature of the work, each discipline in the health care organisation is relying on the other's discipline to achieve their ultimate goal, which is better patient care.

2.3 Belongingness in education

In being concerned with helping students gain essential skills to succeed, educators involved must begin their roles by helping students to develop the internal motivation to learn. According to Erwin (2004), the first step to developing internal motivation is to create a classroom environment that encourages students to meet five basic human needs. Erwin referred to the five basic human needs in the classroom as: i) survival – students need to feel physically and emotionally safe and secure in classrooms, ii) love and belonging – connection and cooperation with other students and teacher, and a feeling of giving and receiving affection helps in student's learning and achievement, iii) power with – the power is achieved through cooperation and competency; for example, by allowing students to participate in developing the classroom rules or behavioural guidelines. When students are given this opportunity, their behavioural problems reduce significantly and they work harder on their assignments, iv) freedom – helps to prevent boredom or unpleasantness and, v) fun – must be a regular part of the classroom to motivate students to learn (Erwin, 2004, pp. 12 - 17).

There is no doubt that students' satisfaction with school experiences has been linked to their sense of belongingness, connection to school, and achievement (Shaunessy & McHatton, 2009). Goodenow (1993) defined sense of belonging in the school context as the extent to which students feel personally accepted, respected, included, and supported by others (teachers and peers) in the academic classroom setting and of feeling oneself to be an important part of the life and activity of the class. It also involves support and respect for personal autonomy and for the student as an individual. Another definition by Cueto, Guerrero, Sugimaru, and Zevallos (2010) of sense of belonging in a school context is the degree to which students feel integrated with their peers and teachers.

A sense of belonging to a community, such as school, has been proposed as a basic psychological need for students (Osterman, 2000). During the period of adolescence, which is part of the schooling period, the need to connect with others through mutually supportive relationships is at its peak. Within this period of adolescence, students begin to consider their capabilities, aspirations, and as a result, the utility value of engaging in academic pursuits (Midgely, Feldlaufer, & Eccles, 1989). Osterman (2000), in a systematic literature review of secondary or high school students' sense of acceptance within the school community, found that students who experienced acceptance were more highly motivated and engaged in learning and more committed to school. When students experienced acceptance and perceived that they were supported by others, including peers and teachers, their sense of belonging increased and they were more willing to help other students.

It has been proposed that a sense of belonging has links with future decisions. Walker and Greene (2009) studied 249 students from three different high schools in Midwestern America, aged between 14 and 19. Walker and Greene found that when students believed that they were valued members of their classroom community, felt supported by both teachers and peers, and believed that the work was an asset to their future, they were more likely to start focusing on their career development. Walker and Greene did not, however, describe the background of the three high schools involved in their study; for example, whether the students came from high-achieving schools in which the students could be easily motivated. Conversely, Walker and Greene (2009) emphasised that "resilience and learning do not occur in isolation. Instead, learning is a complex process that must take into account the central role of personal interactions, and the perceptions that stem for those interactions" (p.464)**.** In other words, the perception of belonging within school and community settings, as fostered by the recognition of a supportive environment, has been found to positively impact students' engagement and

performance in education (Cueto et al., 2010), and the quality of student learning (Osterman, 2000).

In contrast, low sense of belonging at school can lead students to face difficulty in sustaining academic engagement and commitment in environments where they do not feel valued and welcome, thus feel alienated at school (Juvonen, 2006). Cueto et al. (2010) reported that rejected or controversial children were more likely to break school rules. This in turn may lead to other negative consequences such as poor achievement and eventually dropping out of school (Cueto et al., 2010). It can be summarised here that the findings from these studies suggest that when an environment is perceived to be uninviting or non-supportive, students are likely to distance themselves, either psychologically, physically, or both, from that environment. This can also be seen in nursing education and will be further discussed in the next chapter.

It has been suggested that teachers play a significant role in creating belonging in students at school. In order to understand students' academic lives, Wentzel and Asher (1995) studied 423 students from sixth and seventh grade, aged between 11 and 13, coming from Midwestern America. These researchers found that being liked by teachers was more important when compared to acceptance among peers. The cause of this finding, however, was not determined. The students' perceptions of being liked by teachers might have been influenced by the perception that teachers held higher hierarchical power and were responsible for writing students reports. Therefore, it was important for these students to think that being accepted by teachers was more important than peers due to power relationships, like those in the workplace.

2.4 Belongingness in the workplace

Establishing a sense of community at work is essential in developing work relationships (Blatt & Camden, 2007). Blatt and Camden (2007) defined a sense of community at work as a situation where people feel a sense of belonging, and they feel that they matter to each other and to the organisation. The need to belong in a workplace may be satisfied by a particular job, work team, work unit, division, career development, personal support, organisation or industry as a whole (Kahn, 2007). Avey, Avolio, Crossley and Luthans (2009, p. 177) further emphasised that when people felt they belonged to the organisation, their need for belongingness was met by "having a place" in terms of their social and socio-emotional needs being met. Avey et al.'s study comprised a heterogeneous sample and demographic background of 316 working adults in the United States from a wide cross-section of organisations. Avey et al. found that when employees felt ownership in an organisation, they tended to engage in positive behaviours driven by a sense of responsibility that accompanied the feelings of ownership.

In the work setting, Maslow's model still has five levels; however, Maslow (2000) modified the definitions in the following manner: the first basic level that must be satisfied is that of wages. Sufficient wages will help to fulfil the basic needs such as food and shelter. The hierarchy continues by having safety on the job, including freedom from anxiety and stress. Ashkanasy, Hartel and Zerbe (2000) suggest that the working life of the modern employee is more pressured today compared to any other previous time. Ashkanasy et al. (2000) further emphasise that although anxiety and stress may be a constant, these elements should be considered on an individual basis.

Once the stress level is acceptable for an individual, and basic safety conditions as defined by the individual have been met, they would then consider the third stage, which is identified as

the social level. This area includes the need to belong with one's colleagues at the workplace and sense of belonging to the organisation. The hierarchy then continues to achieve self-esteem, which is at the fourth level, and self-actualisation at the fifth level (Maslow, 2000). In terms of belongingness within the workplace, Maslow (2000) believed that people will seek pleasant working relationships with co-workers, peers, and others in the hierarchy. They will seek to find their social place in formal and informal work groups. Ryan and Deci (2000) further supported Maslow's notion of belongingness in the workplace by describing the experience of social integration with colleagues, referring to feelings of belongingness and connectedness to others, and being integrated into the work community and acknowledged by colleagues. In this theory of human needs in the workplace, Maslow still applied the same theory that needs at the lower levels must be fulfilled before those needs at a higher level could be attained. Again, Maslow's theory in the working environment has never been confirmed through research as the theory is derived most directly from experience and depends upon research yet to be done (Maslow, 2000). Therefore, its strength and validity remain under question. Again, despite this, Maslow's theory provides a comprehensive understanding of basic human needs, and brings understanding of what motivates people in the workplace. Maslow's theory continues to be adopted in various disciplines such as education (Ahl, 2006), social science (Paris & Terhaar, 2010) and health science (Zalenski, 2006). Therefore, for the purpose of this study, Maslow's theory of human needs in the workplace has been chosen as a point of reference.

2.5 Belongingness and work motivation

As mentioned in Chapter Two, the need for belonging is among the most powerful sources of human motivation, be it in human relationships, school, or workplace (Baumeister & Leary, 1995; Maslow, 1943). Work motivation has been defined as "a set of energetic forces that originate both within, as well as beyond, an individual's being, to initiate work-related

behaviour, and to determine its form, direction, intensity and duration" (Donovan, 2002, p. 53). In the work context, motivation is defined "as an individual's degree of willingness to exert and maintain an effort towards organisational goals" (Franco, Bennett, & Kanfer, 2002, p. 1255). Workers' motivation is the result of interactions between individuals and their work environment. Porter and Lawler (1968) proposed a model of intrinsic and extrinsic work motivation. They described intrinsic motivation as involving people doing an activity because they found it interesting and derived spontaneous satisfaction from the activity itself. One way of providing intrinsic motivation is by creating multiple job positions, thus making the job more interesting, creating more intrinsic reward, and producing total job satisfaction (Porter & Lawler, 1968). On the other hand, extrinsic motivation requires an instrumentality between the activity and some separable consequences such as physical, material, or verbal rewards (Porter & Lawler, 1968). Therefore, satisfaction does not truly come from the activity itself but rather from the extrinsic consequences to which the activity leads, such as higher salary and job promotion (Gagne & Deci, 2005).

In earlier research, Deci (1971) performed an experimental study on university students in New York, USA, finding that, through feedback or consequences related to worker performance, intrinsic motivation to work would improve. This finding was further supported by Fisher (1978) who conducted an experimental simulation study in America on 82 part-time workers involved in a short-term clerical job. He found that intrinsic motivation was not really affected by the amount paid for the work. It was found to be more affected by the giving of positive feedback which promoted a sense of competence when people felt responsible for their successful performance (Fisher, 1978). In contrast, frequent negative feedback, which decreased perceived competence, was found to undermine both intrinsic and extrinsic motivation, leaving people less motivated (Deci & Ryan, 1985). Thau, Aquino and Poortvliet (2007) conducted a study among employees of a clinical chemical laboratory in the

Netherlands and found that employees who had control of their job and perceived they belonged to the workplace were more helpful, more competent and more willing to perform their job. This suggests that feelings of competence, as well as feelings of autonomy, are important in achieving intrinsic motivation. Besides intrinsic motivation, some people played on certain strategies to make themselves belong (Deci & Ryan, 1980).

2.6 Strategies for seeking acceptance and belonging

Acceptance and belonging offers a wide array of benefits including specific rewards and opportunities. Baumeister and Leary (1995) emphasise that, whether the process of seeking acceptance and belonging involved motivational or perceived benefits of acceptance, one must take care to behave in ways that will lead others to accept them. Through the process of concept analysis, Hagerty et al. (1992) delineated two dimensions of sense of belonging which included valued involvement and fitting in. According to Hagerty et al. (1992), valued involvement is the experience of feeling valued, needed and accepted, while fitting in involves the person's perception that his or her characteristics articulate with, or complement, the system or environment. Malouf and West (2011) describe fitting in as being about "feeling one's self to be part of a social group". How people try to accommodate themselves in a group or relationships and how they maintain rapport that has been established is discussed further in the following section.

2.6.1 Ways to fit in

In facilitating acceptance, a wide range of tactics can be chosen according to how the person wants other people to evaluate them, or to the situation involved during the process of finding ways to fit in. Jones and Pittman (1982) identified five primary self-presentational tactics to foster individuals' relational value. The tactics include: 1) ingratiation – efforts to be

perceived as friendly and likeable, 2) self-promotion – demonstrating intelligence and competence, 3) exemplification – being responsible and morally exemplary, 4) supplication – helplessness. That is, people may convey impressions of neediness or helplessness to enhance their relational value to those who wish to be helpful, and 5) intimidation – threatening. In this tactic, the person will show others that they are the sort of person who responds with anger and aggression to signs of disinterest or rejection by others. By doing this, they will enhance relational value at the price of liking and goodwill, and may lead others to value their relationship as a means of avoiding social costs. This type of person, nonetheless, will promote value to others via the threat of punishment.

Even though threatening other people could be one effective way to promote acceptance, focusing on good manners is more proper in promoting acceptance. Leary (2010) suggested that people are more likely to seek approval by trying to lead others to like them rather than dislike them. Being friendly, sincere, caring, fun and easy to talk to are more attractive to initiating a relationship than being boring, offensive, superficial, self-centred, and mean (Leary, Tambor, Terdal, & Downs, 1995). With greater chances of being accepted, people use behavioural tactics such as praising, and expressing interest in the other person (Deluga & Perry, 1991; Gordon, 1996). These behavioural tactics, according to Folkes and Sears (1977), will not only create liking for the targeted person, but also to other uninvolved observers. Vonk's (2002) experimental study on psychology students' behaviour in the Netherlands found that people liked those who flattered them even if they doubted the sincerity of the people who ingratiated them. It is, therefore, not surprising that people might develop behaviours, even automatic behaviours, which may help them to achieve and maintain relationships with important others.

Another way people seek to fit in is by mimicking. Evidence from previous studies suggests that people mimic the behaviours of those they might want to like them. Lakin (2003) suggests that mimicking nonverbal behaviours of others creates liking and rapport, and may therefore represent one way to affiliate with someone new. Maurer and Tindall (1983) experimentally explored the link between behavioural mimicry and rapport on eighty adolescents in America who came to seek career plans. In the study, Maurer and Tindall sought to determine whether a counsellor who was mirror imaging a congruent arm and leg position of a client would significantly increase the client's perception of the counsellor's level of empathy above the level of the client's perception when the counsellor did not mirror image congruent arm and leg position. They found that when the counsellors had postural congruence with the clients, the clients felt that they received a greater level of empathy from the counsellor and felt more relieved. Maurer and Tindall (1983) further contended that mimicked participants also felt they were much more similar to the person they talked with and believed that the person more likely thought as they did. Findings from Maurer and Tindall's study, however, were limited to the aspect that their participants were adolescents who might still be influenced by other peoples' gestures.

Studies have found that mimicry can happen in any situation. Another experimental study on mimicry was conducted by Chartrand and Bargh (1999) with thirty-five university students in America. They found that people also mimicked the mannerisms of complete strangers. In this study, participants interacted with two interviewees with two different types of behaviour. One interviewee was trained to engage in face rubbing, while the other interviewee was trained to engage in foot shaking. None of the participants in Chartrand and Bargh's study reported having pre-existing rapport or the intention to develop future rapport with the interviewee. Results revealed that even though the interviewee was a stranger to the participants, the participants unconsciously mimicked the mannerisms of the interviewee.

Participants shook their foot more when they were with the foot shaker and rubbed their face more when they were with the face rubber. It can be seen here that participants changed their own behaviour to match their environment. Therefore, it can be suggested here that mimicry behaviour is more likely to depend on the provoking situations and surrounding environments. Again, the sample used in the study came from university students. Being students, young adults are known to be more impressionable and tend to copy other people's behaviour. Therefore, the findings may not actually represent an adult's way of mimicry.

Another way to fit in is by successful achievement. According to Baumeister and Leary (1995), being seen as a competent person in any event doubled the chances of being accepted. Successful people are more likely to be accepted by a group or relationship for their skills that benefit other people, wise opinions, high salary, or just to feel connected with the successful one (Leary, 2010). However, even though successful and competent people are more likely to be accepted, some people will react by following the conditions that surrounds them. Thornton, Audesse, Ryckman and Burckle (2006) conducted two studies examining opposing self-presentational strategies for impression management on 249 adolescents in America. Thornton et al.'s study found that the particular strategies used were based on their specific needs at the time. For example, individuals may either "play dumb" or pretend to "know it all".

Playing dumb can be characterised as feigning ignorance or ability despite having the relevant knowledge or ability. Some people will use this strategy when they try to fit in with people who might be put off or threatened by their knowledge or competence. Therefore, playing dumb is actually driven by a desire to be liked by others (Thornton, Lovley, Ryckman, & Gold, 2009). Among the earliest psychologists investigating human behaviour, Komarovsky (1946) studied 153 female students enrolled in sociology courses in 1942 and 1943 at an

Eastern College in America. From 73 sets of autobiographical data provided and 80 interviews conducted, Komarovsky found that women were more prone to play dumb in a variety of situations including education, relationships, and marriage. One of the limitations of this study is that it was biased to women's status, as Komarovsky did not make comparisons with men. Furthermore, the findings need to be treated with caution as the sample sizes were small and did not represent the overall female population.

Indeed, Komarovsky's (1946) finding on the female playing dumb has not been echoed by other researchers. In a study undertaken by Gove, Hughes and Geerken (1980) among 2247 adults in the United States, it was found that playing dumb was not characteristic of women only, as men may play dumb as often as women. In the job setting, regardless of gender, Gove et al. found that lower income or lower job position and younger people or new workers who had recently joined the work area tended to use 'playing dumb' as one of their strategies to keep going in their working environment. In Gove et al.'s (1980) study, women used this strategy to avoid threatening men in order to maintain their relationships or marriage. Wives played dumb in conditions where a display of superior knowledge would tend to undercut the husband's assumed superior status. Komarovsky (1946) however emphasised that playing dumb was not recommended as a long term event as it would lead to disappointment and stress to the person who pretended they were dumb.

On the other hand, pretending to "know it all" entails professing knowledge or ability despite having little or no real knowledge, understanding or ability. People may use this strategy to be perceived as competent and intelligent by their partner or working colleagues (Thornton et al., 2006). Even though "playing dumb" or "knowing it all" were among those effective strategies to belong, Thornton et al. (2006) and Gove et al. (1980) found that these strategies were actually associated with poor social and psychological health, including lower self-esteem,

social anxiety, emotional insecurity, alienation, vulnerability to criticism, public self-consciousness and greater fear of negative evaluation. Playing dumb and pretending to "know it all" have links with nursing and is discussed in greater detail in Chapter 3.

Other than behaviour, physical appearances have also been found to play an important role in influencing acceptance by other people. Langlois et al. (2000) in their meta-analysis of adult and child attractiveness found that attractive people were judged and treated more positively when compared to less attractive people. This situation could occur even with those who knew the person very well (Langlois et al., 2000). Therefore, people would try hard (for example, crash diet to get an ideal body weight) even though they knew the danger of their action. Viewed in this way, virtually anything that people do to enhance their physical appeal is done primarily to promote relational value and acceptance (Leary, 2010). Once people find their way to fit into a group, they have to figure out how to maintain and secure their place in the group or relationship to avoid being a social outcast.

2.6.2 Ways to maintain belongingness

In earlier societies, living within a group was crucial to secure physical and emotional support. If one could not get along easily with the group members, that person would have to leave the group and find another group that they could fit into. According to Coon (1946) and Proirier and McKee (1999), individuals who were excluded from the group were less likely to survive. They faced many problems including lack of resources to capture and secure their own food, having no protection from their group, and were prevented from forming bonds that provided social connectedness (Lancaster, 1986). Therefore, individuals who were cooperative and able to maintain harmonious relationships with other group members had an advantage and were more likely to continue to be included in the group (Lakin, 2003; Lakin

& Chartrand, 2005), and hence satisfy the need to belong (Baumeister & Leary, 1995; De Cremer, 2002).

Given that people will reject other people who confront a group's judgment and decision, people tend to play safe and conform to others' views without further objection (Janes & Olson, 2000). These types of people have been identified as: 1) those who feel desperate to be accepted as a member of the group, or 2) those who think group harmony is more important (Baumeister & Leary, 1995; De Cremer, 2002). They will think carefully before voicing their objections and might withhold information that could undermine group harmony. Therefore, it can be summarised here that the effectiveness of a group discussion actually reflects on how far members of a group are willing to be brave in voicing their opinions. Maintaining harmony by cooperating with others has been linked with nursing, as by nature of their work, nurses are most of the time bound to work in a team.

It is expected that people with a strong need to belong would cooperate the most. To confirm that the need to belong and cooperation are related to each other, De Cremer and Leonardelli (2003) set out their study focusing on this relationship. Participants in De Cremer and Leonardelli's study were 42 Dutch undergraduate students at one university in the Netherlands. Even though De Cremer and Leonardelli found that cooperation increased as the need to belong increased, the relation between these two variables was not significant. The small sample size of De Cremer and Leonardelli's study might limit the generalisability of the findings. Furthermore, ideally this relationship should be tested in a real situation, for example, the workplace, rather than participants being studied using a simulated environment in a laboratory.

2.7 Implications of lack of belongingness

The need to belong has been proposed as fundamental to human psychological wellbeing. Findings from previous studies suggest that lack of a sense of belonging has been linked to stress, anxiety, and low self-esteem. The issues of how being a social outcast and self-esteem influence sense of belonging are discussed next.

2.7.1 Social outcast and low self-esteem

Belongingness has been persistently stated as the precursor to the achievement of self-esteem (Maslow, 1954). Therefore, Leary, Tambor, Terdal and Downs (1995) evaluated the hypothesis that the self-esteem system functions as a sociometer. Sociometry involves identifying and measuring interpersonal relationships within a group (Berg, 1998). According to the sociometry hypothesis, a self-esteem system exists in humans in order to inform people about potential social exclusion. Therefore, self-esteem could be affected by threats of social exclusion; when exclusion occurs (or the threat of exclusion is present), self-esteem could decrease, which will motivate people to behave in ways to reduce or eliminate the threat of exclusion (Lakin & Chartrand, 2005).

Maintaining self-esteem is considered fundamental in human socialisation. In Leary et al.'s (1995) five series studies conducted on adolescents in America, it was found that the effect of specific behaviours on participants' states of self-esteem depended on whether they thought engaging in the behaviours would lead others to accept or reject them. For example, volunteering to donate blood would make one think that many other people would accept him or her into their group. This acceptance will make the person feel proud. Cheating on a final exam will make another think that many other people will reject him or her. This rejection will make the person feel ashamed. Leary et al. (1995) revealed that self-esteem traits predicted the extent to which people felt they were socially included or excluded. The

predictions were based on the concept that the lower sense of belonging people felt, the lower their state of self-esteem would be; the more respondents felt they did not belong, the less were their feelings of adherence to the organisation or setting (Leary et al., 1995).

The consequences of social exclusion include emotional, psychological, and behavioural disturbance. Leary, Cottrell, and Philips (2001) and Leary et al. (1995) contend that being excluded from a group causes a significant decrease in the state of self-esteem, especially when exclusion is a result of group choice rather than random factors. This decrease in self-esteem occurs for people who acknowledge being affected by the social evaluations of others, as well as those who deny that their self-evaluations are affected by others' opinions (Leary & Cox, 2008; Leary et al., 1995). Therefore, it can be summarised here that the sociometry hypothesis puts forward that self-esteem provides an indicator of an individual's current level of sense of belonging.

2.8 Summary of the chapter

The concept of belongingness, as this review has highlighted, is one of the important aspects of human relatedness. Belongingness has received great attention in many disciplines involving human needs and motivation. It is considered a fundamental human need which can be applied to any discipline including nursing, psychology, social science, and education. Failure to maintain belongingness in relationships, working environments, schools or groups may lead to devastating consequences for psychological wellbeing, and ostracism, rejection, and other forms of social exclusion. People may experience anxiety, low self-esteem, dissatisfaction with their own self and surroundings, and many other unpleasant feelings when sense of belonging is not met. People tend to do unquestioning things or mimic other people in order to be accepted or to make themselves feel they belong to the group. Nevertheless, the

feelings of ‘I belong’ help in promoting comfort and self-esteem. In the next chapter, belongingness in the context of the nursing profession is discussed.

Chapter Three: Belongingness in Nursing

3.1 Introduction

In the previous chapter, belongingness was argued to be a critical element of individual actions and behaviour, and also an influencing factor of group acceptance and performance. This chapter explores literature on belongingness specifically from a nursing perspective. Although the importance of belongingness is mentioned frequently in the literature, in the discipline of nursing, it is an area among experienced nurses that has not been widely researched. A significant body of literature exists about nursing students and new graduate nurses and the workplace within their first year after graduation. Some literature has described concern about preparation of new graduates to function effectively in the clinical environment, including their feelings of 'fitting in' to their new workplace. However, only a few studies have examined the value of belongingness experiences among nurses as they continue their journey in the clinical workplace.

An extensive literature search was conducted using the keywords: nursing, nurses, organisational culture, workplace, intrinsic feelings, belongingness, belonging, sense of belonging, fit, and acceptance. The search was performed using databases including PsycINFO, CINAHL, MEDLINE, PubMed, Cochrane library, and OVID MEDLINE. Search engines such as Google and Google Scholar supplied other information related to belongingness in nurses' workplaces, and assisted in narrowing the search to significant sources. Resources sourced, included journal articles, dissertations, and books. This chapter presents belongingness literature in nursing, starting with nurses as students, followed by newly graduated nurses, and then experienced nurses as they continue their journey in the workplace.

3.2 Belongingness concept in the nurses' workplace

Achieving belongingness in the nurses' working environments is considered challenging, as the environment involves collaboration with various professionals, such as physicians, medical technologists, and administrative staff who have responsibility to work together as teams towards better patient care and the hospital's organisational outcomes. Collaboration is about working together with other people and is linked to relationships (Cox, 2010). The ultimate goal in this collaboration process in the nurses' workplaces is for nurses to build strong interpersonal relationships with other health care providers. As emphasised by Cox (2010), poor interpersonal relationships will result in conflict with colleagues and other healthcare disciplines, which can be a source of chronic frustration. Interpersonal relationships that have been indicated as antecedents of workplace conflict include: i) individual characteristics; for example, differing opinions, demographic dissimilarity which includes gender and educational differences, ii) interpersonal factors; for example, lack of trust, disrespect, and inadequate or poor communication, and iii) organisational factors; for example, interdependence (Almost, 2006). In the past, nurse-doctor conflict was found to be one of the major conflicts in nurses' working environments (Corwin, 1961; Kramer, 1974).

In an adaptation of Maslow's model to nursing practice, Paris and Terhaar (2010) aligned the hierarchy with the nursing practice environment needs as constituting: i) proper work schedules, breaks, and manageable work-flow as the physiological needs, ii) safety in tasks including sufficient nurse-to-patient ratios, and good physician-nurse relationships, iii) good communication, collaboration and teamwork with colleagues and other disciplines to enhance the sense of belongingness, and iv) job autonomy, decision-making ability, and control over practice to enhance confidence and self-esteem. When nurses do not feel that their basic practice environmental needs are being met, they will be less motivated and less likely to progress to the higher-level functions (Chinnis, Summers, Doer, Paulson, & Davis, 2001). In

other words, progress towards achieving self-esteem or true self-actualisation in the workplace will be thwarted unless belongingness, acceptance and appreciation of the nursing profession are experienced first.

3.2.1 Belongingness and nursing students

A seminal study on nurses' perspectives of belongingness was undertaken by Levett-Jones (2007). Levett-Jones's study focused on the implications of belongingness among third-year nursing students from two universities in Australia and one university in the United Kingdom. Using a mixed-methods approach, Levett-Jones set out her study to identify the relationship between belongingness and clinical placement experiences of nursing students by measuring the extent to which students experienced belongingness related to their clinical placements. She explored the factors that impacted on their belongingness experiences and the consequences of the experiences. Three hundred and sixty-two students answered the Belongingness Scale – Clinical Placement Experience survey, and 18 of those students participated in in-depth semi-structured interviews. Demographic characteristics of respondents in Levett-Jones' study, (i.e. age and gender) were found to not have a strong influence on students' experiences of belongingness. It was the interpersonal relationships forged with the registered nurses students worked with on a day-to-day basis that exerted the single most important influence on the students' sense of belonging.

Acknowledging that clinical experience is important in nursing education, Levett-Jones, Lathlean, Maguire and McMillan (2007) emphasised that the quality of clinical placements is vital to the development of competent and confident professionals. The longstanding and multidimensional nature of problems that surround students' clinical placements (e.g. lack of support and opportunity), were explored and reconceptualised through the lens of 'belongingness' (Levett-Jones, et al., 2007); the findings support the influence of

belongingness in nursing education (Levett-Jones & Lathlean, 2007). Levett-Jones and Lathlean further contend that clinical leaders/managers who were welcoming, accepting and supportive, and nursing staff who were inclusive and encouraging, significantly promoted the sense of belonging among nursing students. These types of nursing staff helped students feel they were being valued and respected as members of the nursing team (Levett-Jones & Lathlean, 2007).

Concerned with clinical environment climates, Levett-Jones, Lathlean, McMillan and Higgins (2009a) stated that nursing staff were judged by nursing students according to whether they were friendly and welcoming to nursing students in their ward; such judgement results "worked like a barometer where receptiveness and approachable staff were seen as very supportive" (Levett-Jones, et al., 2009a, p. 319). In return, students would actively participate in ward activities and ask questions, as they felt more comfortable, secure and reported increased confidence. Levett-Jones and Lathlean (2007) emphasised that good quality mentorship received during clinical placement was also identified as important to students' feelings of connectedness and fit. Subsequently, the experience of belongingness was seen to have an influence on students' potential for learning and future career decisions. A higher sense of belonging encouraged students to stay in the nursing profession, as it reduced their anxiety, and increased their sense of wellbeing and motivation to learn (Levett-Jones & Lathlean, 2007).

Parallel with findings from psychology, education and workplace literature as reflected in Chapter Two, unreceptive and unwelcoming clinical environments were found to create feelings of alienation among nursing students (Levett-Jones & Lathlean, 2007), and alienation is said to result in anxiety, depression, lack of motivation, and lack of direction (Hajda, 1961). Levett-Jones and Lathlean (2007) expressed their concern for nursing students who felt

unwelcomed as they found that, to avoid alienation due to unwelcoming environments, nursing students frequently engaged in strategies such as conformity and compliance. Niven (2000) described conformity as an action that occurs where individuals yield to group pressure without direct request to do so. In contrast, compliance occurs in circumstances where people will alter their behaviour in response to a direct request to do so.

Acceptance received from nursing staff was considered vital for the nursing students in Levett-Jones and Lathlean's (2009b) study. By practising 'do not rock the boat' behaviour, nursing students believed they would improve their likelihood of acceptance by the nursing staff they worked with during clinical placements (Levett-Jones & Lathlean, 2009b). Again, retrieving their findings from the Australian and British belongingness study, Levett-Jones and Lathlean (2009b, p.p. 346-347) found that even though nursing students witnessed nursing practice that provided "more harm than good", nursing students were reluctant to risk being alienated from the staff nurses they worked with by reporting the incident to another nurses or nursing leader. However, when the nursing students felt comfortable with, and accepted by, the staff in the clinical environment, and became increasingly confident in the nursing environment as they progressed through the programme, they were found to be more willing to challenge poor practice (Levett-Jones & Lathlean, 2009b).

In recognition of the significance of the influence of belongingness on nursing students' learning, Levett-Jones and Lathlean (2008) contended that strategies need to be developed in order to enhance students' belongingness and social wellbeing during clinical placement. By intensifying the sense of belonging, Levett-Jones and Lathlean (2008) believed students could direct their energies and attention towards learning to care for patients. A five-stage needs hierarchy model was suggested as the most suitable strategy for understanding and explaining nursing student needs (Levett-Jones & Lathlean, 2009a). The ascent to competence

conceptual framework for the hierarchy of needs, which was based on the original Maslow's (1987) hierarchy of needs model, resulted. It included: i) the needs of physical and psychological safety and security, ii) belongingness and feeling accepted (which includes the need for harmony between one's professional values and those of the team), iii) self-concept (which includes the need to be appreciated, recognised and respected), iv) learning in a supportive environment, and v) the need to become a competent, confident and capable professional towards patient-centred care.

Not so different from Maslow's notion of human needs, the conceptual framework of Levett-Jones and Lathlean (2009a) also suggests that competence can be only achieved when needs of safety, security, belongingness, self-concept, and learning are satisfied, indicating that nursing students make progress according to their stage of development. Based on this framework, the clinical placement experience of nursing students was reconceptualised through the lens of belongingness, leading to the conclusion that belongingness is a prerequisite for clinical learning (Levett-Jones & Lathlean, 2008). Levett-Jones and Lathlean (2009a) further contended that the five-stage needs hierarchy model was also suitable for application as a productive instrument for the clinical environment. Although Levett-Jones and Lathlean's (2009a) hierarchical model seems intuitively correct, caution has been recommended as it was only based on one mixed-methods study on nursing students' experiences of belongingness in the clinical workplace (Watson, 2009). However, Levett-Jones and Lathlean (2009c) have rebuffed the criticism.

Based on the importance of belongingness, Levett-Jones, Lathlean, Higgins, and McMillan (2009b) developed the Belongingness Scale-Clinical Placement Experience (BS-CPE) scale. The BS-CPE assesses: i) the degree to which an individual feels safe, accepted, valued, and respected by the other members of the group; ii) the degree to which an individual feels

connected to or included in the group; and iii) the degree to which an individual feels that professional and personal values sought by them are in harmony with the values pursued by the group. The Belongingness Scale-Clinical Placement Experience (BS-CPE) was used in this current study as it provides a more comprehensive belongingness scale measurement and reflects nurses' clinical workplaces; it is discussed further in Chapter Four. According to Levett-Jones, Lathlean, Higgins, and McMillan's (2009c) study of nursing students from Australia and England, which used the BS-CPE instrument, the sense of belonging was found to influence all the elements of self-concept, self-efficacy, resilience, confidence, willingness to question or conform to poor practice, career decisions, and motivation to learn. These findings indicate the value of the BS-CPE instrument in measuring the belongingness of nursing students to clinical placements.

It is evidenced from Levett-Jones' (2007) study that clinical placement is crucial for nursing students to transfer their theoretical knowledge from school into practical knowledge in the clinical area. However, due to the requirements of their educational programmes, nursing students need to be exposed to various clinical experiences (i.e. medical, surgical, orthopaedics, intensive care, paediatric, obstetric, gynaecologic, etc.). These requirements caused nursing students to move to clinical areas. Frequent changes of placement have been found to make students often feel like 'newcomers' and feel alienated owing to the short time they spend in placement areas during the practical placements (Spouse, 2000). On every new placement, students need to build or re-build their relationships with ward staff. Therefore, to be supported and accepted as part of the nursing team, and to be valued as learners, are among the important aspects in their progression to becoming nurses (Bradbury-Jones, Sambrook, & Irvine, 2011; Levett-Jones et al., 2009a), or midwives (McKenna et al., 2013).

Supportive clinical environments have been reported to influence sense of belonging among undergraduate nursing students in Canada (Sedgwick & Rougeau, 2010). Similarly, a study by McKenna et al. (2013) among undergraduate midwifery students in Australia found that when the clinical environment was appropriate, one in which students felt welcomed and accepted and ward staff and preceptors were supportive and encouraging, students felt comfortable to ask questions regarding practices that they observed or request assistance in the care they performed. Being valued as a team member and having a legitimate place in the nursing team has been shown to make nursing students feel more empowered and able to learn effectively (Bradbury-Jones et al., 2011; McKenna et al., 2013). Bradbury-Jones et al. (2011) explored nursing students' experiences in clinical practice in the United Kingdom, capturing experiences of nursing students as they progressed from their first year through to third year. Through the years, students were found to have better competency. The more they progressed, the more they experienced being valued and their input was recognised by ward staff. The more they perceived they were being valued and recognised, the more they progressed to be more confident and able to perform nursing care independently and competently (Bradbury-Jones et al., 2011).

Unfortunately, there are also many examples of disrespect and disregard of students as learners, with a lack of encouragement and responsibility given to nursing students impacting on students' lack of knowledge and confidence. Nursing students reported they were often ignored or excluded during clinical placements (Hoel et al., 2007). Hoel et al.'s (2007) study of nursing students in England found that students were often treated as 'an extra pair of hands', setting them to carry out simple and repetitive tasks, especially when the ward was understaffed. The nursing students' clinical years were not mentioned in Hoel et al.'s study. The generalizability of the findings to other settings needs to be treated with caution, as

students' experiences vary from placement to placement depending on the place's management and culture, including students' perceptions of bullying.

The experience of students being treated as an 'extra pair of hands' has also been reported in other nursing literature. As an 'extra pair of hands', students were seen as not important, lacking knowledge, and as dependent on other nursing staff, thus preventing them from learning what they were supposed to learn during their clinical placements and not helping to promote their self-confidence (Bradbury-Jones et al., 2011; Levett-Jones et al., 2009a; Newton, Billett, & Ockerby, 2009). Whilst students' experiences and perceptions might vary, these negative behaviours need to be attended to. Evidence from previous studies has shown that supportive clinical environments for nursing students are not only required for students to achieve their required clinical competencies, but also play a positive influence on their future careers (Levett-Jones & Lathlean, 2008; Sullivan, Lock, & Homer, 2011).

Clinical placements might bring pleasant or uncomfortable experiences to nursing students. Melia's (1987) seminal study in the United Kingdom to explore and understand how nursing students get through their clinical placements, found that, to survive in the clinical practice environment, avoid feelings of alienation and to be accepted by ward staff, nursing students needed to be quick at their tasks, not ask too many questions, work hard, and to 'look busy' even when the ward was quiet. 'Getting the work done', 'learning the ward rules' and 'fitting in' were identified by the nursing students as their priorities to survive each time they were on clinical placement (Melia, 1987). Nolan (1998) conducted interviews with six second-year undergraduate nursing students in Australia to explore their clinical learning experiences. Nolan's study focussed on how students thought, acted and reflected on their clinical experiences. The students described how their need to fit in and be accepted by staff dominated their thoughts and how conformity was considered essential to their survival

(Nolan, 1998). Students felt safe by ‘doing it the hospital way’ and chose to keep quiet rather than challenge staff. Keeping a low profile and not asking too many questions might be one of the most effective way for the students to ‘fit in’, but it also reduces students’ learning opportunities (Nolan, 1998).

Twenty years from Melia’s (1987) study, findings suggest that students’ clinical learning experiences have not changed significantly. Using grounded theory methodology, Ousey (2007) performed in-depth interviews and observation during the clinical placement of fifteen nursing students, ranging from first to third year, in the United Kingdom. Similar to Melia’s (1987) and Nolan’s (1998) studies, Ousey (2007) found that the students wanted to be viewed as valuable members of the ward and eagerly wanted to “fit in”. The students believed that the ward staff would accept them if they undertook the tasks allotted to them without any further questions. Students felt they were part of the team and “fitted in” when they understood the ward routine (Ousey, 2007). The students described how their position within the nursing staff was perceived as tenuous, they were located at the outer fringes of the group, and because of this they explained how they would not even open their mouth to challenge or contradict the nurses they worked with.

Findings from the above previous studies, (Melia, 1987; Nolan, 1998; Ousey, 2007), may be linked to the roles of staff and students in the clinical area. Students perceived the registered staff to be experts who possess in-depth knowledge bases. As such they respected their authority. The students respected the ward staff, so that, when they were asked to perform certain procedures, they would often do so without question, as it was a more senior person who had asked them. At times, when the students did not fully agree with what they were being asked to undertake, they would not directly question the staff instructions, but would

either increase their own knowledge base through reading information or asking a member of lecturing staff when they returned to the school (Ousey, 2007).

When students face a situation where various members of the ward possess quite different views on how a procedure should be carried out or how the ward routine should be organised for a particular shift, students have been found to act in different ways dependent upon the situation they are in. For example, if the nursing students were uncertain about procedures, and the ward staff who order them to perform the procedures were unfriendly, the nursing students would perform the procedures according to the direction given by the unfriendly ward staff and confirm later with their lecturing staff (Ousey, 2007). Although students are encouraged to question practices while in clinical placement, findings from Sedgwick and Yonge's (2008) ethnographic study of twelve fourth year Canadian nursing students and six preceptors found that to be accepted by nursing teams, students needed to be aware of the norms operating in the clinical area. The students were aware of the hierarchical structure of the nursing staff on the ward which meant 'know your position', 'you are a student here', and 'respect other people'. They often perceived that as students they did not possess the authority or power to ask questions. Students felt a need to conform to the norms to avoid some restrictions being placed on them (Sedgwick & Yonge, 2008).

It is evident that a supportive clinical environment is crucial to promote a sense of belonging among nursing students. Ousey (2007) argued that in order for learning to occur in the clinical area, it had to be managed by a leader who was in touch with the needs and abilities of subordinates. With the support of the ward leader, other nurses would feel comfortable in taking on the mentor role and in developing the learning environment (Ousey, 2007). It is important for nursing students to have mentors or staff who can be good role models in the

clinical area, to help students to fit in and feel they are welcomed and valued members of the ward team.

Other than a supportive clinical environment, Levett-Jones et al. (2009c) proposed that the duration of students' clinical placements also influenced students' experiences of belonging. Levett-Jones (2007) found that the UK mean belongingness score was the highest in their study when compared to the Australian site. This was influenced by the fact that the nursing students in the UK had longer clinical placements. Levett-Jones et al. (2009c) reported that nursing students focused on 'settling in' and 'becoming part of the team' at the start of each placement. This suggests that the objective of the clinical placements is not fully achieved if the clinical placements duration is too short, as nursing students are busy with their own personal objectives. Levett-Jones et al.'s notion that short clinical placements are insufficient to promote belongingness was supported by Melia (1987), Nolan (1998), and Ousey (2007), as discussed earlier in this section.

The scenario of being 'too busy to belong' reflects situations elsewhere in the world. Lee, Lim and Kim's (2011) and Kim and Jung's (2012) studies among Korean nursing students found that short durations of clinical placement, defined as two weeks per placement, were found to hinder the nursing students from building good rapport with nursing staff. As the rapport was not very good, the nursing students felt it difficult to adapt to the clinical environment, and therefore experienced a lower sense of belonging during clinical placements (Kim & Jung, 2012; Lee et al., 2011). Levett-Jones et al. (2009c) contended that nursing students should spend at least four weeks in a clinical placement to enable them to be involved in the placements. The duration of clinical placements is important for nursing students to develop a sense of belonging, improve self-concept, develop a degree of self-efficacy, confidence, resilience, willingness to question or conform to poor practice, inform

career decisions, and promote motivation to learn (Levett-Jones et al., 2009c). Entering the work environment after graduating from nursing school means that graduates carry a real nurse's responsibility in the clinical workplace. In order to understand the importance of belongingness for graduated nurses in their workplaces, the concept of belongingness in nurses' workplaces is discussed next.

3.2.2 Graduate nurses and belongingness

A search of nursing literature of graduate nurses and belongingness found that there is a gap where previous studies on belongingness have focused more on belongingness experiences of newly graduated nurses. The idea of focusing more on newly graduated nurses might be influenced by the notion that belongingness during adolescence has been identified as crucial, as, during this period, teens reportedly struggle to achieve autonomy and develop self-identity (Booker, 2006). For novice nurses, the need to achieve autonomy and develop self-identity highlights the importance of belongingness upon graduation from nursing school. Many nurses experience self-doubt (Etheridge, 2007) and self-conflict (Kramer, 1974) during this time after their graduation period. Self-doubt is described as a feeling when the nursing student is not trusting his or her own capability to take responsibility for patient care (Benner, 1984), and to enter the real world of the working environment (Etheridge, 2007). Self-conflict, as described by Kramer (1974), is the feeling when the newly graduated nurse encounters a system of values in the work setting incongruent with the roles and values learned in school. What was learnt at nursing school – for example, decision-making, leadership, and patient care – is confronted by bureaucratic principles, rules, and regulations that operate in the hospital (Kramer, 1974).

Building upon Kramer's (1974) work, Duchscher (2009) presented her concept *transition shock* by trying to understand the graduates' responses to their new reality. Based on studies

conducted from the previous ten years, Duchscher (2009) indicated that "transition shock emerged as the experience of moving from the known role of a student to the relatively less familiar role of professionally practising nurse" (p. 1105). Newly graduated nurses anticipated that some adjustments would be necessary prior to their professional work situation, but they thought they would at least be affirmed through a positive work experience; for example, welcoming colleagues, being recognised for the knowledge they had acquired and the commitment they had made to caring for others, thus helping them adjust to their new life (Duchscher, 2009). As the reality within the first few months was not as they expected, Duchscher found that most newly graduated nurses were unaware of "the toll" this transition would take on their personal energy and time, and also on their evolving professional self-concept. Newly graduate nurses expressed their transition shock as: i) emotional – feeling anxious due to inadequate and insufficient functional and emotional support, lack of practice experience and confidence, unrealistic performance expectations by colleagues and institution, self-fear if other people saw them as incompetent and rejected them, and struggling to incorporate and maintain their practice intention and standards acquired during their education, which they believed were a basic requirement of their professional role, ii) physical – feeling exhausted and energy depleted in adjusting themselves to a new life, as the reality of how difficult and unpredictable working in the clinical area is had never been revealed to them before they entered the real world of working as a staff nurse, iii) socio-cultural development – feeling a lack of self-confidence and struggling to work and communicate with senior nurses and physicians whose behaviour reinforced hierarchical rather than collegial relationships. Considerable stress was involved in supervising, delegating and providing direction to others, many of whom were senior to the new graduates in both practice experience and age. This new experience of collaborating with others, especially the seniors, was something they had never been introduced to, prepared for or allowed to practice during their undergraduate education, and iv) intellectual – feeling disorientated, confused and shocked due to theory/practice incongruences and practice improprieties, lack of

knowledge on transition, lack of awareness regarding graduate roles and responsibilities and limited performance feedback (Duchscher, 2009, pp. 1106-1109).

Preparatory theory about role transition for senior nursing students and bridging undergraduate educational curricula with workplace expectations have been proposed to help newly graduated nurses overcome the reality shock phase (Duchscher, 2009). It includes: i) educational theory that accommodates varying learning styles and modes of knowledge transition, ii) role playing or contextually-based learning scenarios that engage both novice and experienced nurses and other health care team members related to the stages of transition and the experience of transition shock; for example, what to expect and when, intergenerational and inter/intra professional communication, and workload delegation, as in delegating to individuals older and more experienced (Duchscher, 2009). Placing new graduates in an acute care unit, for example, a critical care unit, or in a floating position such as a relief team, straight after they graduate was considered not a good decision as the management needs to take into consideration new graduates' cognitive processing ability during the early stages of their professional socialisation period (Duchscher, 2009). Duchscher further proposed that, within their first twelve months, new graduates should be placed in consistent and stable clinical settings and gradually increase their exposure, receive regular and frequent feedback, be offered opportunities to share their experience and be encouraged to collaborate with colleagues and other health care staff. This may help the newly graduated nurses adjust to their role, feel supported and hence experience a heightened sense of belonging.

In order for new graduates to develop a sense of belonging within their workplace environment and with colleagues, a supportive environment has been identified as essential to help in developing the novices' professional roles and skill acquisition (Kramer, 1974;

Zinsmeister & Schafer, 2009). As discussed by Hagerty and Patusky (1995), a sense of belonging will help to promote personal involvement in an environment so the person will feel an integral part of the system. Even though Kramer (1974) proposed that supportive environments are essential to reduce reality shock, studies on newly graduated nurses' experiences continue to report a lack of sense of belonging due to unsupportive clinical environments experienced within the first months they report for duty as registered nurses (Casey, Fink, Krugman, & Propst, 2004; Kim, Park, & Han, 2007; Kovner, Brewer, Fairchild, Poornima, & Kim, 2007). Furthermore, Kim et al.'s (2007) study reported that novice nurses in Korea experienced a sense of loneliness and lack of belongingness during their first year after graduation due to unwelcoming work environments, such as experienced nurses being unwilling or too busy to teach them.

Another study conducted by Kovner et al. (2007) reported that new graduates in the United States experienced inadequate support from supervisors, ward managers and senior nurses. Some participants in Kovner et al.'s (2007) study reported they had been verbally abused when they made mistakes or asked questions, and experienced poor teamwork and poor collaboration with colleagues. Casey et al. (2004) studied the stresses experienced by cohorts of graduate nurses working in six acute care hospitals in Denver, United States during the first 12 months of employment. The study found that the newly graduated nurses experienced a lack of acceptance from the experienced nurses. They felt under-respected by the senior nurses as the senior nurses always referred to them as 'the new grad nurse'. The newly graduated nurses also mentioned they were labelled as not 'in tune with' because their time management was poor (Casey et al., 2004). Similar to findings from Kim et al.'s (2007) study, participants reported that they felt alone, being left on their own with a tremendous amount of responsibility and yet no one was there to guide them (Casey et al., 2004). Even though the new graduates stated they experienced a lack of belongingness due to being undervalued,

feeling a lack of acceptance and support, and lack of feedback from ward managers and colleagues, they were fearful about voicing it and verbalised that they needed to earn trust from their colleagues and managers to fit in the ward community (Casey et al., 2004; Kovner et al., 2007).

It has been proposed that job stress among newly graduated nurses is linked with lack of confidence. Etheridge (2007) defined confidence as "the belief in oneself, in one's judgement and psychomotor skills, and in one's possession of the knowledge and ability to think and draw conclusions" (p. 25). Etheridge (2007) studied newly graduated nurses' experiences within the first six months of working in West Michigan Hospital in the United States. The novices reported that once they were out of nursing school, they did not feel as confident as they wished when the work demanded them to start assuming responsibility for their actions. Most of the nurses were afraid of not knowing what to do with each patient and not knowing how to interpret patients' data. Similarly, a study by Andersson and Edberg (2010) in Sweden found that newly graduated nurses were afraid to make decisions on their own and would seek somebody with more experience – for example, a preceptor, nurse manager or other experienced colleague – to validate the decisions they made.

A supportive workplace environment has been proposed as an effective way to help newly graduated nurses overcome their fears within the first few months after graduation. A qualitative study of newly graduated nurses' experiences in the Republic of Ireland conducted by O'Shea and Kelly (2006) found that all ten participants described being nervous and frightened within the first few months of their clinical placements. Insomnia, loss of appetite, loss of weight, anxiety, and stress were reported by all of the participants. Feeling under-confident with their actions, they sought opinions from senior nurses to confirm their thinking and actions. Even though many nursing studies suggest that lengthening nursing students'

clinical workplace experiences would help in enhancing newly graduated nurses' confidence levels, Andersson and Edberg (2010) contend that this lack of confidence seems to occur with every newly graduate nurse, regardless of the support, (that is, preceptorship or orientation programme) they received. Three months was the minimum length of time that has been proposed for gaining confidence (Andersson & Edberg, 2010; Etheridge, 2007). Novice nurses reported the most influencing factors for them to gain confidence was support provided in the workplace and through their relationships with colleagues, particularly the experienced nurses (Andersson & Edberg, 2010; Newton & McKenna, 2007).

Besides developing confidence in patient care, seeking acceptance and respect from colleagues in the work area have also been found to be important elements during the first few months following graduation. Andersson and Edberg (2010) and Fink and Krugman (2008) reported that nurses expressed the view that being accepted and respected as colleagues was more important than being accepted and respected by patients. The newly graduated nurses were eager to fit in and strove for acceptance. They wanted to feel acceptance and have the sense of belonging to the staff and the unit as soon as possible. Therefore, they sometimes hid their insecurities behind a mask of competence and self-confidence (Andersson & Edberg, 2010) as one of their strategies for becoming part of the team.

Focusing mainly on their own survival and ability to perform tasks within the first six months has been found to be the main objectives of new graduates in Australia (McKenna & Green, 2004). Subsequent studies by McKenna and Newton (2008) and Malouf and West (2011) on new graduate nurses in Australia found that new nurses did not feel they belonged, feel accepted by colleagues, and treated as equal colleagues until they were placed to work in one particular unit. In Australia, many public and private hospitals offer formalised twelve-month duration graduate nurse programs that provide graduates with rotations through a number of

clinical areas. New graduates have described this period of time as extremely stressful and lacking in a sense of belonging (Malouf & West, 2011). This lack of a sense of belonging would hinder confidence by interfering with the independence process as practitioners (McKenna & Newton, 2008).

Researchers have reported that playing safe by not showing their true capabilities has been observed in newly graduated nurses' early experiences in the workplace. A study conducted by Etheridge (2007), found that, besides having a lack of confidence, new graduates sometimes appeared to possess their knowledge to a limited degree. This is what is known as 'playing dumb'. Similarly in Taiwan, Yeh, Wu and Che (2010) found that, in order to fit in, newly graduated nurses pretended they knew nothing about certain issues or procedures, even if they had learnt them at nursing school. Even though nurses knew the right thing to do for the patient, or observed other nurses' unethical behaviour, the nurses chose to keep silent due to nurse-nurse domination and a desire to maintain acceptance by colleagues (Yeh et al., 2010). In a situation where proper role models, advice, or guidelines were unavailable, Yeh, et al. (2010) found that the newly graduated nurses merely followed the example of senior nurses, even if they doubted whether their practice was correct. This type of action would only cause the newly graduated nurses to be obedient to the senior nurses and foster bad influences on a positive ward culture.

The strategy of playing dumb and following instructions does not only occur in nurse-to-nurse relations, but also with other health care team members, especially doctors (Malloy et al., 2009). In Yeh et al.'s (2010) study, the newly graduated nurses obeyed doctors' orders, dared not point out mistakes and remained silent, despite their objections (Yeh et al., 2010). By doing this, nurses were actually avoiding creating tense situations in their working environment. Levett-Jones et al. (2007, p. 216) stated that "conflict became intense when

participants did challenge the ward staff's behaviour and attitudes and these confrontations sometimes led the participants to experience emotional and/or physical reactions, for example, crying, headache, and insomnia". This may explain why people tend to follow the available rules and regulations of the organisation as they want to avoid exclusion from groups and maintain a strong need to belong.

In contrast to playing dumb, Malouf and West's (2011) study in Australia found that some new graduates tried to 'fit in' by pretending to 'know it all'. The new graduates demonstrated that other people's perceptions of them were very important in determining their abilities to be able to 'fit in' to the clinical environment. Therefore, they did not want other people to perceive them as 'stupid', even though they lacked knowledge (Malouf & West, 2011). In Malouf and West's (2011) study, appearing 'stupid' referred to feeling ignorant of local social knowledge, being uninformed about nursing practices used in the clinical environment, or raising concerns that their care might be unsafe. Therefore, participants usually problem-solved their questions using their own skills and abilities rather than asking others, thinking twice before asking questions because they were scared the questions were too simple or they would be perceived as knowing very little about the clinical world; they noted down medical terms they did not know and checked them in their own time, rather than addressing their learning needs. The literature confirmed that 'fitting in' is a very important feature in the transition process of becoming a registered nurse.

The only study on belongingness and more experienced nurses located through the literature search was from Paton (2010). Paton conducted a phenomenological study of belongingness in one hospital in Canada with fifteen registered nurses who had various years of nursing experience, ranging between one to more than twenty years. Themes described by Paton (2010) as what participants understood by the term 'belongingness' included: i) a sense of

feeling happy, comfortable, and being part of a family within nursing practice, and ii) feeling stressed, alone and afraid when experiencing lack of belongingness. Nurse leaders were identified as having a major role in creating a sense of belonging through recognition, support, feedback, and consultation. Together with the organisation, nurse leaders had a responsibility to ensure that a culture of belongingness existed in the workplace (Paton, 2010). Without a sense of belonging, nurses' intentions to leave were higher when compared with other workplace environments that had managers or leaders who actively worked to generate caring relationships and supportive work settings (Paton, 2010). Findings from Paton's (2010) study suggest that belongingness works as a motivator in the workplace, thus creating positive behaviours among staff.

3.3 Achieving job autonomy in nursing

Job autonomy has been defined as the degree of discretion that employees have over important decisions in their work, such as the timing and methods of their tasks (Parker & Wall, 1998). Job autonomy has been identified as one of the important features of work design for employee outcomes such as job satisfaction and motivation (Parker & Wall, 1998). Diers (2004, p. 205), commenting on the role and power of autonomy in nursing practice, suggested that:

> It is a useless and draining exercise for a nurse to have the responsibility, but not the authority, or the accountability without the responsibility. When those three come together, the work role becomes coherent and the potential impact not only on patient care but on system reform is revealed.

Hodson (2001) argues that the three elements of responsibility, authority, and accountability are not easy to achieve, as nursing managers frequently seek to limit the autonomy of the professional in order to gain control of and organise work according to their own agendas.

In addition to the fact that nursing managers seek to control their nurses; the community seems very selective in terms of looking for knowledge providers. In clinical fields, doctors can easily attain trust from patients and families due to their authority and domination. Yeh et al. (2010) found that no matter how much nurses tried to satisfy patients and their families, the nurses' words were not as effective as one word from a doctor. Yeh et al. (2010) also found that doctors in Taiwan used their power of authority when interacting with nurses, for example, in making decisions or dealing with unresolved matters. Chang, Ma, Chiu, Lin and Lee (2009) compared level of job satisfaction, collaborative relationship and teamwork among 1475 healthcare professionals in four hospitals in Taiwan. They found that nurses perceived less teamwork than other healthcare professionals. Nurses felt that their input was not well received and they were less involved in decision-making, especially when the discussion involved people of higher ranking. There might be elements of cultural influence in Yeh et al.'s (2010) and Chang et al.'s (2009) studies as the hierarchical power of medicine and nursing is strong in Taiwan due to the influence of the Taiwanese cultural and traditional values (Chiang & Pepper, 2006).

The hierarchical power between nurses and physicians, nurse managers and subordinates is reflected on elsewhere. Daiski's (2004) study among Canadian nurses also reported that many participants were aware of the hierarchical power. Similarly, Thomas, Sexton and Helmreich's (2003) study about teamwork in critical care units among ninety physicians and 230 nurses in Texas, U.S., also found that hierarchical power influenced the teamwork between nurses and physicians. Even though the majority of nurses in Thomas et al.'s study were senior nurses (mean of nine years of critical care experience), most of the time nurses still found it difficult to speak up due to environmental factors, such as hierarchical power. What limits the generalisability of hierarchical power in nursing contexts is that, in spite of the influence of cultural values in eastern countries, there is no research comparing the

strength of hierarchical power between eastern and western nursing settings. Therefore, the differences of hierarchical influence between eastern and western contexts remain uncertain. Subsequently, frequently facing situations of being undervalued and having a lack of autonomy could just hinder a sense of belonging and might encourage nurses to be silent knowers.

3.3.1 Silent knowers

There is no doubt that nurses spend more time with hospital inpatients than other health care practitioners. Nurses spend twenty-four hours a day with patients and are more involved with patients' suffering and hope (Running, Hoffman, & Mercer, 2008). Evidence has shown that nurses participating in rounds for the first time (Andersson & Edberg, 2010), or even after the first time (Malloy et al., 2009), were anxious that others, including colleagues, other health care team members and physicians in particular, would not pay attention to their views on the patients' conditions. Knowledge gap, lack of experience in the clinical area, and self-perception of nursing as subordinate makes nurses feel afraid of saying the wrong thing or making a mistake in their statements (Andersson & Edberg, 2010). Belenky, Clinchy, Goldberger, and Tarule (1986) suggest that this type of person is the 'silent knower'. This type of knower is the one who remains silent for most of the time because they lack confidence to speak their mind. Therefore, they accept authority as their legitimate source of knowledge, while their knowledge base remains unarticulated and embedded in silent practice (Meleis, 2012). This is particularly problematic for the nursing profession as, with lack of confidence in certain situations, due to the power of other staff in the workplace, nurses cannot successfully participate in discussions pertaining to patients' needs and have difficulty in building professional relationships with nursing colleagues and the other health care team members, which helps in shaping their professional identities. Meleis (2012) further suggests that these people may be competent practitioners but find it difficult to have their views heard.

It is important, though, to understand that, despite nurses believing that they are aware of patients' needs and wishes, and capable of recommending treatment, they choose to keep silent and perceive that their opinions and suggestions are going to be ignored by others. Belenky, et al. (1986) indicated that silent knowers typically come from an environment in which their emotions are not positive and their desires or opinions are not acknowledged by others. Belenky et al.'s notion was supported by Gershon et al.'s (2007) systematic review of health care organisational climate and nursing in the United States. Gershon et al. (2007) found that nurses' voices were often silenced by the system of the organisation, physicians, patients and their families. The findings indicated that the influence and practice of hierarchical power was the culprit (Gershon et al., 2007). This situation makes the person feel that they do not belong to the environment as their view is not appreciated by others. Therefore, as proposed by Belenky et al. (1986), the phenomenon of silent knowing may be more accurately considered as a product of the environment.

Feeling comfortable with the surroundings has been emphasised as one important component for humans to feel confident to speak (Eells, Seals, Rockett, & Hayes, 2005). People speak when they know that others hear their voice. Generally, the higher interdependence among disciplines, the more frequently each discipline must communicate. Thus, when there is no agreement in the communication process, conflict will occur (Daft, 2010). Conflict in an organisation can lead to misunderstanding, under-appreciation of work-related roles and responsibilities, and inconsistent decision making (Morrell, Brown, Qi, Drabiak, & Helft, 2008). When nurses perceive they have little control within their work setting, they are perceived by other health care team members as having a lack of knowledge, and their actions are restricted by medical dominance, frustration and dissatisfaction will occur and job satisfaction will never be fully met (Zurmehly, 2008).

3.4 Belongingness outcomes

The literature demonstrates that belongingness is able to influence outcomes of any organisation. The outcomes, either negative or positive, depend upon the lack of, or sufficient sense of, belonging offered by the organisation. Amongst the outcomes influenced are job satisfaction and self-esteem.

3.4.1 Job satisfaction

Job satisfaction can be defined as the extent to which employees like their work (Stamps, 1997), and the work environment (Huber et al., 2000). Job satisfaction is an important issue because it has been identified as a prediction of nurse turnover (Chang et al., 2009; Winter-Collins & McDaniel, 2000). In nursing literature, various reasons have been identified for job dissatisfaction among both novice and experienced nurses. Such reasons include: i) poor public image and continued subservience to physicians (Begat, Ellefsen, & Severinsson, 2005; Cohen, 2006); ii) poor relationships with colleagues, lack of communication between staff nurses and managers, lack of effective nursing leadership within the workplace (Buerhaus, 2005; Lewis, 2007); iii) lack of support in practice settings between nurses and between nurses and nurse leaders (Buerhaus, 2005); and iv) lack of effective teamwork between nurses, and between nurses and other health care team members (Chang et al., 2009). These factors are all linked to belongingness.

In the workplace, a person could concurrently be satisfied and dissatisfied with the work environment (Herzberg, 1966). Factors such as achievement, recognition, advancement, nature of the work, potential promotion and responsibility (Altier & Krsek, 2006), a higher level of teamwork and adequate staffing (Kalisch, Lee, & Rochman, 2010) have been identified as among the satisfying factors in nurses' workplaces. Chang et al. (2009)

conducted a cross-sectional survey study in four hospitals in Taiwan finding that, for all four hospitals, the existence of good collaborative interdisciplinary relationships was one of the most important predictors of job satisfaction for all healthcare providers. Similarly, a study was conducted by Gill, Deagan, and McNett (2010) on graduate nurses' expectations, perceptions and satisfaction in the workplace during their first year of employment in one hospital in Ohio, United States. Gill et al. (2010) found that, when nurses perceived that collaboration between disciplines and good relationships between nursing colleagues, nurse managers, and the other team members was present, they typically reported higher levels of satisfaction and less intent to leave the nursing profession.

In contrast, factors such as being undervalued (Cohen, 2006), poor relationships with colleagues, lack of communication or poor quality of interaction between colleagues, staff and managers, and with other health care team members (Lewis, 2007; Winter-Collins & McDaniel, 2000), lack of effective leadership (Lewis, 2007), and lack of support between staff, and between staff and managers (Buerhaus, 2005; Paton, 2010; Winter-Collins & McDaniel, 2000) have been identified as dissatisfying factors in nurses' workplaces. Maslow (1954) believed high levels of satisfaction with the workplace to be an intrinsic motivator to the worker. Once the worker feels satisfied, he or she will feel motivated and start to produce higher-level work performance. Therefore, exploring belongingness from the nurse's perspective might help to identify areas to improve job satisfaction.

3.4.2 Self-esteem in nursing

Self-esteem has been defined as "the evaluation that individuals make and customarily maintain with regard to themselves. It expresses an attitude of approval or disapproval towards the self." (Rosenberg, 1965). Rosenberg, Schooler and Shoenback (1989) further contend that the process for achieving self-esteem involves three elements: i) reflected

appraisal of an individual's interpretation of how others view them, ii) social comparison which involves viewing the self in comparison to other people, and iii) self-attribution, which is about drawing conclusions about one's self from seeing the successful and unsuccessful outcomes of one's actions. Hornby and Turnbull (2010) in The Oxford Advanced Learner Dictionary of Current English defined self-esteem as "a feeling of being happy with one's own character and abilities". Maslow (2000) pointed out that any worker must be treated with a certain respect, no matter how minor a contributor he or she may be, because each worker is also a team member of the organisation, and deserves respect and a sense of belongingness from other team members.

When someone does not achieve the satisfaction of the need to belong, Leary et al. (2001) found that there will be a decrease in self-esteem and that person will tend to have more pro-social behaviour. A person who experiences low self-esteem will face an uncomfortable sense of insecurity which leads to problems such as anxiety (McInnes, 2006; Rosenberg, 1965). On the other hand, Suliman and Halabi (2007) conducted a study on 165 nursing students in Saudi Arabia and found that higher self-esteem was significantly correlated with a higher ability in critical thinking. This finding paralleled Maslow's theory of human needs where the level of self-esteem has its influence on the person's creativity and ability for critical thinking.

Even though, in the workplace, Maslow (2000) strongly emphasised the importance of achieving belongingness for development of self-esteem, he contended that there was a difference between esteem and self-esteem. The need for esteem is from others, and the need for self-esteem is a combination of that from others and from one's own life (Maslow, 2000). In regards to cultural and hierarchical influence on the nursing profession, nurses themselves need to work towards acceptance by other health care team members. Academic education, it is suggested, has the potential to increase nurses' self-esteem. Eckert, Gaidys and Martin

(2012) examined self-esteem in 212 German nurses using the Rosenberg Self-Esteem Scale. Eckert et al. (2012) found that nurses with an academic degree displayed a statistically significant higher level of self-esteem than nurses without academic degree education.

Self-esteem is an internal factor. It comes from inside the nurses and the nursing profession itself and it cannot totally be corrected by external measures alone (Fabricius, 1999). The effort of promoting self-esteem among nurses, however, can be jeopardised by relationships between nurses themselves. Previous studies have found that relationships amongst nurses were frequently hierarchical and competitive (Daiski, 2004). Nevertheless, nurses have been exposed to this type of relationship for too long (Daiski, 2004; Hutchinson, Vickers, Jackson and Wilkes, 2006). Daiski (2004) found among registered nurses in Canada that nurses did not necessarily support each other during crises, but often sided with people outside nursing, particularly physicians, against their own nursing colleagues. Nurses have also been found to have a tendency to admire and imitate those they perceive as powerful, which most of the time were their oppressors, and to accept their values while disregarding the values of the nursing profession itself (Roberts, 1983; 2000).

Oppressed group behaviour in nursing has been described as nurses being dominated by those considered more powerful, such as physicians, who continue to intrude in nursing matters (Daiski, 2004). Roberts (1983, pp. 26-27) originally described how nurses, frustrated in relatively powerless positions imposed by powerful others, resorted to “oppressed group behaviours”. Not daring to retaliate towards the oppressors, the oppressed group will lash out against their own group and those of lesser status. They also tend to admire and imitate those they perceive as powerful and join the ranks of the oppressors and accept their values while disregarding their own (Daiski, 2004). The resulting internal divisiveness leaves them weakened and further enhances domination from the outside (DeMarco & Roberts, 2003), as

inter-professional and intra-professional hierarchical relationships are inextricably intertwined (Daiski, 2004).

In the nursing literature, oppressed group behaviour has also been known as workplace bullying (Hutchinson et al., 2006; Lowenstein, 2013; Murray, 2009) or when the behaviours occur among those in the same ranks of employment, such as staff nurses, it is referred to as horizontal violence (Jacoba, 2005; Longo & Sherman, 2007). In such cases, nurses are forced to work with unequal power relations (Hutchinson et al., 2006). Perhaps situations at Mid Staffordshire National Health Service Trust Hospital in the United Kingdom of workplace bullying or fear of workplace bullying provide evidences that this type of negative behaviour can create and bring a huge impact on nursing practice, health care organisation and patient safety. The Mid Staffordshire National Health Service Trust Hospital had been accused of high patient mortality and neglect as the hospital management paid more attention to cost cutting and achieving targets, rather than expressing concern about the standard of patient care (Francis, 2013). Staff members (including nurses) who worked at this hospital were ignored when they voiced their concerns. For example, new graduate nurses were put in charge, despite having little knowledge and experience. Nurses were discouraged from speaking out. For example, the nursing shortage was critical but because the hospital wanted the foundation award, staff were discouraged from telling the truth, and many other staff were deterred from speaking out, due to fear of disciplinary action, despite a ‘no blame policy’. Because the staff were often ignored when they spoke up, they had the perception there was no use speaking or submitting their concerns or report as it often brought about no action or change in management (Francis, 2013).

The bullying culture can also involve fear of the power of nurse managers and nurses in charge of wards. In the Mid Staffordshire report, nurses reported that they were scared of the

nurses in charge (ward sisters) and afraid to speak out against the poor standard of care delivered to patients. For example, one nurse who worked in an Accident and Emergency Unit raised issues to the ward sister concerning poor patient care; however, the ward sister's response was extremely aggressive, basically telling the nurse who reported the issue that they (the ward sisters) were in charge. More sadly, the nurse who raised the issue had been accused of not being a good team player. Other nurses who agreed with the issue being raised had been warned and also accused of not providing good teamwork (Francis, 2013, section 1.197, p. 108). As a consequence, nurses in the Accident and Emergency unit were fearful of the nurse managers and sisters, and therefore followed the orders and recorded incorrect information to save themselves from being blamed, as they felt unable to challenge the ward managers (Francis, 2013, section 1.198, p. 109).

The group reported to be most affected by the oppressed group behaviour or workplace bullying in health organisations has been nurses at the lower end of the disciplinary hierarchy who have had little decision-making power and are seldom consulted (Daiski, 2004). In addition to having low self-esteem, frustrated nurses may leave nursing and those who remain are faced with tremendous workloads and burnout, as severe nursing shortages ensue (Masroor & Fakir, 2010). The expert's intention to leave should be treated as an important issue, as his or her clinical expertise and organisational knowledge are invaluable to patients, colleagues, and to the intellectual capital of the organisation. Recruitment itself is a long and expensive process. According to Jones (2002), it takes sixty to ninety days, on average, to recruit a nurse, including the processes of advertising, screening, and interviewing. In addition, it may take another six months for the newly hired nurse to be able to function independently (Winter-Collins & McDaniel, 2000).

3.5 Gaps in the literature

Previous literature has explored belongingness in psychology, as well as contextualised settings such as education and the workplace. Although there has been some research conducted on belongingness in nursing contexts, both Western and Eastern, there is a lack of empirical investigations of belongingness in Malaysia. In addition, most previous studies on belongingness in nursing contexts view the importance and the implications of belongingness in nursing students and newly graduated nurses with work experience between six to twelve months. The current study sought to understand factors that contribute to belongingness among nurses, including new graduates and more experienced nurses, particularly in the Malaysian nursing context. The present study could highlight other aspects that contribute to belongingness in Malaysia, for example, cultural values and social connectedness, and therefore add to the body of existing knowledge of belongingness and nursing in the workplace.

3.6 Summary of the chapter

The literature review identified the influence of sense of belonging in nurses' workplaces. It began by exploring the importance of belongingness and the consequences of lack of belongingness among nursing students, newly graduated nurses, and more experienced nurses. There was an identified gap in the literature on belongingness relationships with experienced nurses. The literature confirms relationships between sense of belonging and nurses' intrinsic feelings of motivation and job satisfaction. Many factors such as nurses' actions and behaviours in the clinical workplace, including intentions to leave nursing practice, are influenced by the feeling of belonging or lack of it. How this literature informed the current study is described in the next chapter. Chapter Four presents a description of the methodology employed in the current study, including population, data collection procedures, and analysis approach.

Chapter Four: Methodology

4.1 Introduction

Building on the material presented in the literature review, this chapter presents a discussion of the underlying principles and approach of the current study. In this chapter, an outline of the mixed-methods study design is given, including a description of the methodology chosen, the research setting, target population and sample methods used for data collection along with ethical considerations. The reasons for these associated choices are discussed. Ethical considerations, approval processes, research setting, target population and sample, and data collection are also described. The quality of the data, including validity, is explained. Coding of data and the tests used for data analysis are discussed.

The chapter is divided into two main sections. First, pragmatism as a theoretical perspective and mixed-methods design are explained. This is followed by an outline of the quantitative and qualitative data collection approaches employed, along with rationales for each methodological decision. The chapter concludes with a description of the data analysis approaches used to manage and interpret the data.

4.2 Theoretical perspective

According to Houser (2012), the philosophical assumptions that drive the design of a study are rooted in the paradigms of the researchers who are doing the studying. A paradigm is an overall practice and belief system that strives to make sense of the nature of reality and the basis of knowledge (Houser, 2012). Creswell (2009) emphasised that the choice of research paradigms and methods is driven by: i) the current state of knowledge about a particular phenomenon, ii) the purpose of the research, and iii) the related research question/s. In this

study, an examination of a wide body of existing literature from the disciplines of social science and psychology revealed that belongingness is a pervasive and fundamental human motivation. In education, belongingness helps to shape a student's identity, social behaviour, and academic achievement. In nursing, belongingness helps to increase work motivation and job satisfaction in the clinical workplace. However, the concept of belongingness has not been explored in Malaysian contexts. In trying to understand belongingness in a Malaysian nursing context, this study sought to explore:

- How Malaysian nurses valued belongingness
- The way Malaysian nurses achieved and maintained belongingness
- The consequences of feeling a lack of belongingness in the nursing profession in Malaysia

It was these issues that provided the guiding parameters from which paradigmatic and methodological decisions were made. In doing so, this study sought to address the following research questions:

1) To what extent do nurses experience the concept of belongingness in the workplace with colleagues, other health care team members, and the organisation?

2) Is there a relationship between nurses' experiences of belongingness in the workplace with their intrinsic motivation, feeling confident, and job satisfaction?

3) What strategies do nurses use to fit in with colleagues and other health care team members?

Belongingness is a complex human phenomenon. Trying to understand the phenomenon within nursing perspectives is challenging. It requires an exploration of nurses' personal thoughts, perceptions, and experiences. Therefore, in order to try to capture the whole picture of belongingness in nursing, it was necessary to engage with multiple perspectives and ways of trying to understand it. Carr, Brockbank, Allen, and Strike (2006) provide the example of

gaining a comprehensive picture of anxiety in women undergoing gynaecological surgery using a mixed-methods approach. The quantitative aspect of Carr et al.'s (2006) study identified how women's anxiety flowed during their time in hospital and confirmed the relationship between anxiety and pain, while qualitative interviews explored events and situations that influenced the women's anxiety. Creswell (2009) further emphasised that both quantitative and qualitative data were often used by investigators because they worked to provide the best understanding of the research problem at that time. Meleis (2012) suggests that in a discipline that deals with human beings, it is perhaps feasible that not only one theory should explain, describes, predict and try to change the discipline's phenomena. Therefore, due to the nature of the research project and the researcher's philosophical assumptions in this study, a mixed-methods approach informed by pragmatism was selected as the most appropriate conceptual framework.

4.3 Conceptual Framework – Pragmatism

Pragmatism is a method of philosophising, often identified as a theory of meaning (Thayer, 1981). The idea of pragmatism was originally introduced by Charles Pierce in the 1870s. Pierce (1905) contended that:

> …the word pragmatism was invented to express a certain maxim of logic… which is to trace out the consequences for deliberate, self-controlled conduct of the affirmation or denial of the concept (p.494).

This notion was further elaborated and revived as a theory of truth by William James and John Dewey who emphasised the importance of the consequences of actions based upon particular conceptions (Cherryholmes, 1992; Thayer, 1981). Dewey (1931) wrote:

> …pragmatism….does not insist upon antecedent phenomena but upon consequent phenomena; not upon the precedents, but upon the possibilities of action…when we

> take the point of view of pragmatism, we see that general ideas have a very different role to play than that of reporting and registering past experiences. They are the bases for organizing future observations and experiences (pp. 32-33).

Pragmatism proposes that research designs should be planned and conducted based on what will best help in answering the research questions, rather than following abstract philosophy (Johnson & Christensen, 2008). In other words, thinking out how to answer the research question has greater influence in the direction of the study than the research methodology itself. Creswell (2007) further emphasised that the outcomes of the research – what are the situations, what are the solutions, and what will be the actions – are the major concerns in pragmatism. Therefore, to achieve the objectives, pragmatism provides freedom for researchers to choose the methods, techniques, and procedures that best meet their needs and purposes (Creswell, 2009), rather than specifically asking about the reality, as there is no restriction to stick to only what will constitute the knowledge (Cherryholmes, 1992).

According to Greene and Caracelli (2003), the essential criteria for making design decisions in pragmatism include: i) practicality - implies a basis in one's experience of what will and what will not work, ii) contextual responsiveness - involves understanding the demands, opportunities, and constraints of the situation in which the inquiry takes place, and iii) consequence - the truth of a statement consists of its practical consequences, particularly the statement's agreement with subsequent experience. Being concerned with single methods focuses on a limited view of reality, thus pragmatist researchers are encouraged to draw liberally from both quantitative and qualitative assumptions when they engage in their research (Cherryholmes, 1992). Taking into account that nursing literature on belongingness and experienced nurses was limited, it was felt pragmatism offered a commitment to what

works in practice, an appreciation of plurality, and a desire for integrated results, hence making this paradigm appropriate for the current mixed-methods study of belongingness.

4.4 Research design – Mixed-methods approach

In the disciplines of psychology and social science, belongingness has been researched primarily using quantitative designs (Levett-Jones, 2007), thus limiting the depth and breadth of the findings. Creswell and Plano-Clark (2007) defined mixed-methods research as involving collecting and analysing data from both quantitative and qualitative perspectives in a single study. By mixing the datasets, Creswell and Plano-Clark (2007) suggest the researcher provides a better understanding of the problem than that supplied by one dataset alone. The numerical data from the questionnaire survey allows for comparison and the testing of relationship between variables (Creswell, 2009), while qualitative data gives personal stories (Johnson & Christensen, 2008) – in this case, how belongingness was experienced by the nurses.

It has been proposed that researchers should consider using a mixed-methods approach when it can provide better opportunities for answering the research questions (Teddlie & Tashakkori, 2003). The quantitative method seeks to answer the research questions, while the qualitative method, besides answering research questions, also attempts to explore the phenomenon of the issue being studied and involves theory generation. Therefore, it is actually a great advantage when the methods are mixed together as it enables the researcher to simultaneously answer confirmatory and exploratory questions, thus, verifying and generating theory in the same study. Secondly, the mixed-methods approach provides stronger inferences when compared to the single method alone. A complex social phenomenon, such as belongingness, requires different kinds of methods to gain better understanding and make inferences about these complexities. This social phenomenon is not easy to fully understand

using either purely qualitative or purely quantitative techniques only. Thirdly, there are opportunities to present greater diversity of divergent views – when the quantitative and qualitative findings may lead to totally different conclusions (Teddlie & Tashakkori, 2003). Therefore, in the current study, choosing mixed-methods was considered the most appropriate strategy to explore belongingness perspectives through Malaysian nurses' experiences.

4.4.1 Quantitative perspective

One aim of the study was to measure and quantify levels of belongingness perceived by Malaysian nurses, and how they valued the concept of belongingness in the workplace. A quantitative descriptive approach using a survey is considered a suitable design when the study intends to measure participants' perceptions (Burns & Grove, 2007; Polit & Beck, 2008). Furthermore, in this study, the researcher intended to explore if there was a relationship between nurses' sense of belongingness, their intrinsic motivation as qualified nurses, and their job satisfaction as well as levels of confidence. Therefore, quantitative analysis could be used to measure relationships. As stated by Houser (2012), quantitative designs are appropriate when the results must reveal the true relationship between two variables.

The descriptive design was chosen to enable the researcher to gather base information about Malaysian nurses' sense of belongingness. This design assists the researcher to discover a baseline level (Houser, 2012). In particular, a descriptive correlational approach was selected because the researcher was primarily interested in describing and examining where relationships existed between variables. For example, is there a relationship between nurses' sense of belonging and years of working experience with their level of confidence? However, an experimental study is needed if the cause needs to be determined (Polit & Beck, 2012; Schneider, Whitehead, Elliott, Lobiondo-Wood, & Haber, 2007). Therefore, in the current

study, the ‘cause and effect’ of the relationship explored would not be determined because this study was non-experimental.

A descriptive study is also useful to obtain information about practices, opinions, attitudes and other characteristics of people (Burns & Grove, 2007). Descriptive designs explore specific populations (e.g. nurses) to examine whether their attitudes toward some issue (e.g. sense of belonging) are related to certain situations (Polit & Beck, 2012), for example, demographic characteristics, socio-economic, health characteristics, experience or knowledge. Furthermore, if the researcher suspects that a relationship might exist in the population, choosing a descriptive study can, therefore, set out to confirm or refute those suspicions (Houser, 2012). Moreover, the design dictates how the variables are to be measured in testing their relationships (Polit & Beck, 2012). In addition, correlational studies are advantageous as the results of the study can be used as a foundation for potential future study (Schneider et al., 2007). In the current study, descriptive design was considered to be the most appropriate method to unfold the issues of belongingness among Malaysian nurses.

4.4.2 Qualitative perspectives

From the qualitative perspective, this method provided an extra advantage in exploring belongingness in Malaysian nurses. Rather than using predetermined information from the literature or relying on results from other studies, this method could provide a rich and deep understanding of the phenomenon undertaken (Creswell, 2007) as belongingness has received little attention with experienced nurses and in Malaysia. In addition, Creswell (2007) also believed that qualitative methods, through interview, are the best way to hear silenced voices from a group or population, as participants are encouraged to share their experiences face-to-face with the researcher. Recognising that all methods have limitations, Creswell (2009) believes that biases inherent in any single method could neutralise or cancel out the biases of

other methods. Information from qualitative data can give additional support in understanding the phenomena of belongingness through contact with personal experiences of the nurses. This researcher chose to employ an approach informed by phenomenology as it deals with human experience.

The Phenomenological approach

Phenomenological research is characterised by beginning in the life world, which means the natural attitudes of everyday life (Van Manen, 1997). From a phenomenological point of view, to do research is always to understand the way people experience the world, and to want to know the world in which we live as human beings (Munhall, 2007). Giorgi and Giorgi (2003) suggest that phenomenology is a study of human consciousness. Phenomenology asserts that, when people are aware of the surroundings, their mind and body become united and start to respond accordingly. This is what they call consciousness (Giorgi & Giorgi, 2003).

As well as dealing with human experience, another important concept offered by phenomenology is its philosophy. Essentially, phenomenology has three major streams of philosophy: 1) the descriptive phenomenology of Edmund Husserl (which generates a description of a phenomenon of everyday experience to achieve an understanding of its essential structure); 2) the hermeneutic phenomenology of Martin Heidegger (which relies on interpretation); and the existentialist phenomenology of Merleau-Ponty and Jean-Paul Sartre (which is focused on perception and creation of a science of human beings) (Holloway & Wheeler, 2010). The method adopted in this study was primarily the hermeneutic phenomenological method as described by Van Manen (1990). It attempted to be descriptive, to show how things looked in the natural way of everyday life, to let nurses speak for their own experience of belongingness in the workplace, and yet, in the context of the hermeneutic

project, it was interpretive. It goes beyond mere description to interpretation. By combining the descriptive (in the sense that it names something) and interpretative (in the sense that it mediates), it gives a better understanding of the phenomenon or lived experience (Van Manen, 1997, p. 26), which, in this study, means belongingness in the workplace among Malaysian nurses.

It has been suggested that interpreting experiences is the most effective way of understanding phenomena. Van Manen (1990) emphasised that the lived experience needed to be captured in language (the human science text), and that is called an interpretive process. The interpreted data then only can aid in understanding the phenomena (Holloway & Wheeler, 2010). Van Manen (1990) argued that phenomenology is not primarily interested in the subjective experiences of the subjects or participants, for the sake of being able to report on how something (for example, belongingness) is seen from their (for example, nurses) particular point of view, perspective or vantage point. The deeper goal is to ask questions concerning the nature of this phenomenon (belongingness) as an essentially human experience. No matter how any particular nurse relates to his or her experience, this study sought to uncover the meaning of what it is to belong, and how it feels when nurses sense they belong to the multidisciplinary workplace.

Phenomenology is not based on any theory, experiment, or observation; therefore, phenomenology does not allow for drawing general conclusions from a particular set or example, nor does it describe actual states of affairs, as it does not ask: Who did what? When? Where? How many? In particular, phenomenological questions ask for the meaning and significance of certain phenomena as it allows for increasingly sensitive awareness of humans and their ways of being-in-the-world. Therefore, Dreyfus (1991) contended that phenomenology does not solve problems. However, as the phenomenon of belongingness in

the workplace is more deeply understood through this method, it was chosen as it may be able to guide nurses to act more thoughtfully and more tactfully in certain situations.

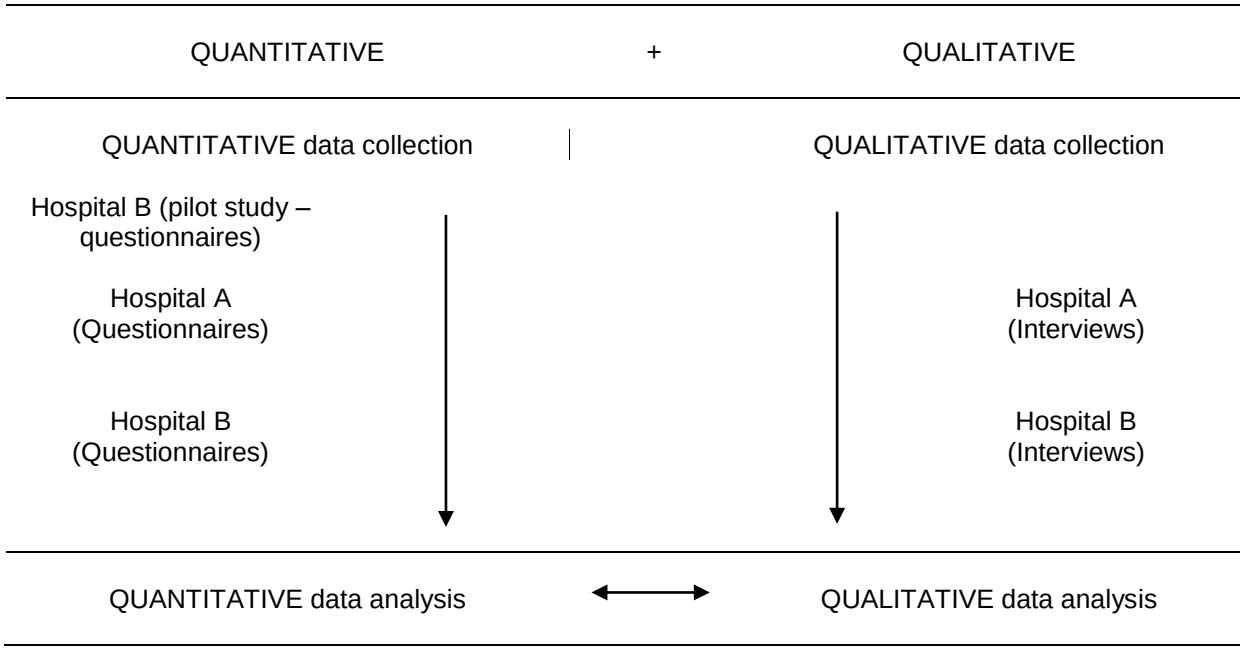
4.4.3 Priority of method

Priority of method, either quantitative or qualitative in mixed-methods study, has been generously debated. A notation system which refers to the components of a mixed-methods study as either core or supplementary has been applied by Morse (1991). For example, a mixed-methods design might entail the use of: 1) a qualitative method to describe some experience, with an additional quantitative strategy to measure some dimension of the experience. Measuring the dimension of the experience enriches the qualitative description of the phenomenon under investigation. Alternatively, 2) a quantitative method might be used to measure some experience, and a qualitative strategy may be added to the research design to allow for description of an aspect of the phenomenon that cannot be measured and that would enhance the narrative description of the phenomenon (Morse & Niehaus, 2009). Even though Morse and Niehaus (2009) asserted that the supplementary component cannot stand alone, as it is not scientifically rigorous and is of use only to the extent that it adds to the understandings generated by the core method, Creswell and Plano-Clark (2007) contend that the mixed-methods researcher can give equal priority to both quantitative and qualitative research, emphasise qualitative more, or emphasise quantitative more, as long as the researcher makes informed decisions clearly during all phases of his or her research. In the current study, both the quantitative and qualitative data were of equal value and neither was assigned a greater priority. The researcher regarded both methods as rigorous and able to offer complementary views on the meaningful understanding of Malaysian graduate nurses' experiences of belongingness.

4.4.4 Concurrent data collection strategy

It has been proposed that a mixed-methods study can employ strategies of inquiry that involve collecting data either concurrently or sequentially in order to understand research problems (Creswell, 2009). In this study, a concurrent data collection approach was selected to allow for a comprehensive understanding of belongingness to be generated. This means that quantitative and qualitative data were collected and analysed simultaneously, and the final results were integrated during the interpretation phase. The advantage of collecting data concurrently is it can be employed to validate one form of data with the other, to compare the data from both methods, and to address different types of question (Creswell & Plano-Clark, 2007). However, concurrent data collection precludes follow-up on interesting or confusing responses. Given that the current study was to be submitted in the fulfilment of the researcher's Doctor of Philosophy, this study was limited to a time period. Therefore, concurrent data collection was chosen as it resulted in a shorter data collection time period compared with that of sequential data collection. Figure 4.1 shows the data collection strategies employed.

Figure 4.1: Concurrent data collection strategy. Adapted from Creswell (2003).



Key

+ indicates a concurrent form of data collection.

⟷ Indicates a simultaneous but separate data analysis phase, followed by interpretation of the results.

4.5 Research Setting

This study was conducted at one public government hospital (named Hospital A), and one teaching hospital (named Hospital B) located in the capital city of Malaysia, Kuala Lumpur. These hospitals were selected for their strategic location in the middle of Malaysia and, as well, they were among the busiest hospitals in Malaysia. They accepted almost all referral cases from all over Malaysia and had among the best services in terms of medical experts, staff, diagnostic equipment, and advancements in hospital technology. Therefore, the researcher was interested to see how nurses developed and maintained their sense of belonging in this busy working environment, under high demand from patients and hospital organisations.

4.5.1 Hospital background

Hospital A and Hospital B were different in background. Hospital A was first established in the late nineteenth century as a district hospital. From the nineteenth century, Hospital A has continued to develop and has been upgraded to be one of the largest government hospitals in Malaysia. In contrast, Hospital B was established in late twentieth century and initially functioned as a teaching hospital for one university in Malaysia. Since then, it has continued over time to develop and was upgraded to be one of Malaysia's primary academic centres under Malaysia's Ministry of Higher Education.

4.6 Target population and sample

This study sought to capture Malaysian nurses' sense of belonging within their working environments and in the health care organisation. The target population consisted of qualified nurses providing direct care to patients and registered with the Malaysian Nursing Board. In June 2012, there were about 63,152 nurses registered with the Malaysian Nursing Board (S. Safiah, personal communication, August 29, 2012). According to Bordens and Abbott (2008, p. 159), the ideal way to capture the whole story is through random sampling in the intended population as it allows for the highest level of generality from research to real life. Therefore, all nurses who met the inclusion criteria were invited to take part in this study.

4.6.1 Inclusion criteria

The intention of the current study was to explore sense of belonging in the workplace, specifically in the clinical area. The researcher believed that this group of nurses were those who struggled every day, every moment, to make themselves belong with colleagues and other health care team members. Inclusion criteria included that participants needed to be: i) nurses registered with the Nursing Board Malaysia, and ii) registered nurses providing direct

nursing care to inpatients in the clinical area at the time of the study. This group of nurses were selected because they dealt directly with patients, relatives and other health care team members.

4.6.2 Exclusion criteria

Exclusion criteria for participants in this study included: i) nurses who were not providing continuous direct nursing care to inpatients in the clinical area; that is, registered nurses working in Operating Theatre, Outpatient Department, Central Sterilising Services Department (CSSD), Continuous Nursing Education (CNE) Unit, Infection Control Unit, and milk room. This group was excluded because they were either involved in limited nursing care with patients for a short amount of time (e.g. Operating Theatre and Outpatient Department); or, they were not involved in direct nursing care that required interactions with colleagues and other health care team members (e.g. CSSD, CNE, milk room). Next, the procedures used for the data collection are explained: the quantitative survey and the qualitative interview.

4.7 Data collection for the quantitative phase

In this section, the data collection process using survey design for the quantitative phase is described. This involves the instruments that were used to collect the data, the pilot study, recruitment strategies, and tests used in analysing the data.

4.7.1 The instruments

A survey design using questionnaire was employed as the data collection technique for this component of the study. Nurses' experiences of belongingness were measured using the *Belongingness Scale in the Workplace survey*, adapted from that initially developed by

Levett-Jones (2007). A copy of the revised questionnaire and permission to use and modify the scale was obtained through direct email communication between the researcher and Levett-Jones. Levett-Jones (2007) had previously adapted this questionnaire from Somers's Belongingness Scale (Somers, 1999). Somers's Belongingness Scale was grounded in the theoretical framework of Baumeister and Leary (1995) who postulated that belongingness functioned across a wide variety of situations and environments. Somers's Belongingness Scale was initially designed to assess belongingness across four interpersonal environments: i) family, ii) friends, iii) work or school, and iv) neighbourhood or community.

As Levett-Jones' (2007) study focused specifically on nursing students' clinical placement, she selected only those items from Somers's Belongingness Scale which related to work or school, and the words 'clinical placement' were substituted for 'work/school' and 'colleagues' for 'co-workers/classmates'. Levett-Jones developed alternative questions based on a literature review conducted on previous studies on belongingness in the workplace. The questions reflect the definition of belongingness by Baumeister and Leary (1995) which concern connectedness (being part of, feeling accepted, and fitting in), and esteem (being cared about, valued, and respected by others). Levett-Jones' (2007) *Belongingness Scale – Clinical Placement Experience (BES-CPE)* comprised a total of 34 questions including sub-scales for self-esteem, connectedness, and efficacy. The validity and reliability of the BES-CPE scale has been previously reported by Levett-Jones (2007), with Cronbach's alpha being reported as 0.92 (Levett-Jones, 2007). Levett-Jones' (2007) instrument has been used by a number of researchers in studying belongingness in different contexts. McKenna et al. (2013) used Levett-Jones's instrument to measure undergraduate midwifery students' sense of belonging in clinical practice in Australia. The same instrument was also used by Kim and Jung (2012) to measure undergraduate nursing students' sense of belonging in clinical practice in Korea. Korkeakouluissa, Muotoilu and Esitutkimus (2013) also used Levett-Jones'

instrument in their pilot study to measure belongingness among students of Finnish universities of applied sciences.

A few modifications to Levett-Jones' (2007) instrument to suit the needs of the current study were made. The words 'my placement' were substituted by 'my clinical workplace'. The words 'colleagues', 'other health care team members', and 'organisation' were added. 'My clinical workplace' in the current study referred to the unit/ward where respondents were based at the time the data were collected. 'Colleagues' refers to other nurses whom participants were working with in the clinical workplace. The words 'other health care team members' referred to other staff in the health care team; for example, doctors, pharmacists, dieticians, radiologists, physiotherapists and so on. 'Organisation' referred to the hospital where the participants worked at the time the data were collected.

Twenty questions were selected from Levett-Jones' (2007) tool to measure belongingness experiences with colleagues. Twelve similar questions were employed to measure belongingness experiences with other health care team members. Eight additional questions were developed through literature review from previous studies on nursing and the organisation. These eight additional questions covered nurses' feelings about the organisation and how they perceived that the organisation treated them. Content validity of the final belongingness questionnaire was then tested and reviewed by a panel of nursing personnel from two different Malaysian hospitals (n = 5, average years of experience = 15). The 40-item revised scale had a Cronbach's alpha value of 0.93, with 20 items relating to colleagues (0.89), 12 items relating to other health care team members (0.83), and eight items relating to the organisation (0.80). The alpha coefficient of the overall items and sections items were 0.80 and above. This indicates that the overall items and all sections items had relatively high internal consistency (Tavakol & Dennick, 2011).

The current study focused on the relationship of belongingness in the clinical workplace with nurses' intrinsic feelings, which included intrinsic motivation, feeling of confidence, and job satisfaction. However, these areas of interest were not covered by Levett-Jones' (2007) study. Therefore, an additional questionnaire was adapted based on a similar questionnaire from a previous study conducted by Konrad et al. (1999). A copy of Konrad et al.'s questionnaire, and permission to use and modify the scale, was obtained through direct email communication between the researcher and Konrad. Konrad et al.'s (1999) study focused on measuring physicians' job satisfaction in the clinical workplace. Their questionnaires contained 49 items based on autonomy, relationships with colleagues, relationships with patients, relationships with staff, pay, resources, and status. New facets included intrinsic satisfaction, free time away from work, administrative support, and community involvement. Physician status items were reconfigured into relationships with peers, patients, staff, and community, yielding ten hypothetical facets. Global scales and items were developed representing satisfaction with job, career, and specialty.

The Cronbach's alpha of the questionnaire has been cited as 0.8 (Konrad et al., 1999). Konrad, et al.'s instrument has been used by Masselink and Lee (2008) to measure workplace relational factors and physicians' intention to leave their work. From Konrad et al.'s instrument, there were a few questions irrelevant to this study which were therefore omitted. The questions omitted were related to physicians' work descriptions, including extra working time, for example, on call and salary. Only those items related to job satisfaction and intrinsic motivation in the clinical workplace were selected. Questions related to feeling confident in the clinical workplace were developed from the previous literature review, as the study by Konrad et al. did not cover this area. Content validity of the final intrinsic feelings questionnaire was then tested and reviewed by a panel of nursing personnel from two different hospitals (n = 5, average years of experience = 15). The 25-item revised scale had a

Cronbach alpha value of 0.87, with nine items relating to intrinsic motivation (0.79), eight items relating to feeling confident (0.76), and eight items relating to job satisfaction (0.78). The alpha coefficient of the overall items was more than 0.8 and sections items near 0.80. This indicates that the overall items and all section items had relatively high internal consistency (Tavakol & Dennick, 2011).

The final questionnaire used (Appendix 1) in this study consisted of four sections. Section A collected demographic information. Section B, based on Levett-Jones' (2007) instrument, measured nurses' sense of belonging in the clinical workplace. Section C, based on Konrad et al.'s (1999) instrument, measured nurses' intrinsic feelings. Section D was designed to identify strategies nurses used to 'fit in' in the clinical workplace, employing open-ended questions. Items in Section B and C were constructed using a Likert scale. To measure attitudes, beliefs, opinions, values and views, a Likert scale is considered the most appropriate tool (Parahoo, 2006). Respondents were asked to express the degree of their agreement or disagreement along point scales. Scores for each item in this study ranged from one to four where 1 represented strongly disagree to 4 represented strongly agree. The total scores represent the strength of particular attitudes, beliefs, opinion, or views (Parahoo, 2006). The questions in the current study included both positive choices and negative choices to minimise response bias. Negative choices in Section B (Q11, Q29, Q33, Q34), Section C(i) Q5, C(ii) Q6, and C(iii) Q3, Q4, Q7, and Q8 were scored via reverse-scoring. The sections of the questionnaires are discussed in more detail below.

Section A: Demographic characteristics

This section consisted of question categories such as age, ethnicity, highest level of nursing education achieved, and years of experience. These particular questions on demographic characteristics were used to gather background information about the participants, and were

later used to see if there was any influence of demographic characteristics on sense of belonging.

Section B: Structured categories concerned with nurses' experiences of belongingness in the clinical workplace.

This section consisted of 40 Likert scale items which aimed to examine nurses' perceptions of their sense of belonging with colleagues, other health care team members, and their organisation based on Levett-Jones' (2007) scale. Feelings of acceptance and being connected in the clinical workplace were measured in this category. These questions were designed to help to determine whether fitting in with colleagues, other health care team members, and the organisation played an important role in nurses' clinical workplaces. Yeh et al.'s study (2010) found that acceptance by colleagues was more important than acceptance by patients. Assessing nurses' sense of belonging and confidence levels with other health care team members was important. If the nurses felt confident and had a sense of belonging to the health care team, they would feel confident to express their opinions to other health care team members and not be silent knowers (Malloy et al., 2009) in their own work environments. A sense of belonging to the organisation also plays an important role as, when workers feel their working organisation is concerned with their welfare and future plans, they will be more motivated to work and increase the quality of work. Workers will give better input through their work when the sense of belonging to the organisation is strong (Avey et al., 2009).

Section C: Structured categories concerning nurses' intrinsic feelings about their clinical work environment

This section consisted of a total of 25 Likert scale items based upon Konrad et al.'s (1999) scale, as follows:

a) A category about nurses' intrinsic motivation. This consisted of nine Likert scale questions and aimed to gain information about the nurses' own levels of motivation. The intrinsic motivation would help in measuring how motivated the nurses were with work in their daily workplace. This category would also help to assess if there was any relationship between belongingness and motivation to work. A study by Avey et al. (2009), as discussed previously in Chapter Three, showed that belongingness indirectly works as a motivator in the workplace, thus creating positive behaviours among staff.

b) A category about nurses' level of confidence. This section consisted of eight Likert Scale items and aimed to gain an understanding of nurses' confidence levels in the workplace. It also aimed to ascertain whether belongingness had an influence on the nurses' levels of confidence.

c) A category about job satisfaction. This section consisted of eight Likert scale items and aimed to provide information about correlations between belongingness and job satisfaction.

Section D: Question on strategies nurses used to 'fit in' in their clinical workplace

This section had one open-ended question asking about strategies nurses used to fit in with their colleagues and other health care team members in the clinical workplace. This open-ended question gave the opportunity for nurses to expand their answers.

The overall questionnaire was first designed in English. However, because all of the participants were Malaysian nurses, it was translated into the Malay language by the researcher. The translated Malay questionnaire was subsequently reviewed with another nursing lecturer in Malaysia to ascertain if there were any items requiring better accuracy, better understanding, or modifications. The revised Malay questionnaire was then checked and back-translated into English by a lecturer in Bachelor in Teaching English as a Second

Language (TESL) in Malaysia. The researcher and one nursing lecturer in Malaysia rechecked the accuracy of the back-translated English questionnaire by comparing it with the original questionnaire. This detailed translation process ensured that questions retained their original meaning. As the original questionnaire had been modified, a pilot study using this Belongingness Scale in the workplace was subsequently organised.

4.7.2 Pilot study

Modifications to available questionnaires by Levett-Jones (2007) and Konrad et al. (1999) were made to meet the needs of this study. According to Johnson and Christensen (2008), the main purpose of a pilot study is to find out whether the questionnaire developed could operate properly before using it in the research field. A pilot study was carried out to see if the content was clear and easy to comprehend, the form of the questionnaire appropriate, and the length of time needed to complete the questionnaire was appropriate. In this study, questionnaires were sent via email to twenty nurses, with varying years of experience, working in Malaysia. Participants were asked to give comments and suggestions regarding the content, wording, and layout of the questionnaire. The feedback was on the translation of the survey, where the sentences in a few questions were seen as a bit confusing. Corrections were made in the sentences that had earned respondents' comments. Comments indicated that instructions were clear, and the font size used in the questionnaire was acceptable.

4.7.3 Recruitment strategies

After the ethics committees (see section 4.10 for the ethics process) from the university and each selected hospital had approved the ethics application, letters of permission were sought from the Head of Nursing Department at each participating hospital to conduct research in the Nursing Department. With the ethics approval and permission letters, the Continuing Nursing

Education Unit (CNE) managers were then approached. Following discussion with the CNE Unit managers, the researcher gave a brief presentation during the hospital's regular continuing nursing education sessions. The audience during the meeting included nurses and nurses-in-charge of the ward at each selected hospital. The aim was to introduce the study to nurses and nurses-in-charge of the unit, to help in recruiting volunteers willing to participate. Advertisement via posters on noticeboards (Appendix 2) around the hospitals was also employed to further prompt participation.

The printed questionnaire, together with the participant information sheet (Appendix 3) attached to it, was distributed to each potential participant during handover report in each unit in the hospital. After 25 days, as the response rate was less than ten per cent of the total population of all nurses working in each hospital, a gentle reminder using a reminder slip (Appendix 4) was placed together with the recruitment poster that was employed earlier throughout the hospital. Pre-labelled sealed envelopes with the project title and designated destination were provided and attached to the questionnaire. Participants were asked to place the completed questionnaire in the pre-labelled envelope entitled 'Belongingness Survey Questionnaire' and send it back through internal mail to a designated locked box located at the nursing administration department of each hospital. The researcher then went to the nursing department to check the box, and collect the completed questionnaires from the locked box on every alternate day.

4.7.4 Test used for data analysis

Data were entered into a computer and analysed using the Statistical Package for the Social Sciences (SPSS) version 19 for Windows. A range of analytical techniques was used to examine the data including:

1) Descriptive statistics (frequency distributions) – to summarise participants' demographic characteristics. This provided information about participants' backgrounds.

2) Chi-square – to examine relationships between demographic characteristics of respondents and their places of work.

3) Mean and Standard deviation – to summarise respondents' belongingness experiences (ranging from the highest to lowest scores) in the clinical workplace with their colleagues, other health care team members, and the organisation.

4) Pearson product-moment correlations – to examine relationships of respondents' belongingness experience scores with their intrinsic feelings; that is, feeling motivated, feeling confident, and experiencing job satisfaction in the clinical workplace.

5) Independent-samples t-test – to explore relationships between scores of belongingness experiences with place of work and gender.

6) A one-way between-groups analysis of variance (ANOVA) – to examine relationships between scores of belongingness experiences with age, years of experience since graduation from basic nursing training, and years of experience in the current clinical workplace.

7) Content analysis – to examine the open-ended question seeking strategies respondents used to 'fit in' to the clinical workplace with their colleagues and other health care team members. Conventional content analysis (Hsieh & Shannon, 2005) was used to explore strategies nurses used to create a sense of belonging with colleagues and the other health care team members. Respondents' answers were divided into various codes according to the same key words.

4.8 Data collection for the qualitative component

The qualitative survey sought to explore the personal experiences of nurses in their workplaces. Personal or face-to-face interviews were used. Polit and Beck (2008) emphasised that personal interviews are regarded as the best method of collecting qualitative data. They provide a high quality of information, and refusal rates from potential participants are low. It also ensures that the person who answers is the one who was intended to answer and there is a reduction in the possibility of outside influences for responses given (Borbasi, Hengstberger-Sims, & Jackson, 2008).

In-depth semi-structured interviews were used as the data collection technique for this qualitative phase. The interview schedule (Appendix 5) consisted of open-ended questions designed to probe participants' experiences and understandings of belongingness in their workplaces. The questions were designed to explore the nurses' actions, the impact and the consequences the nurses felt when, as nurses, they sensed that they did not belong with colleagues, other health care team members, or the health organisation. The guiding question asked of the participants was: "Can you describe your experience of belongingness in your clinical workplace?" or ingratiate, for example, "Is there anything you would like to change about nursing?" This question was deliberately chosen because it sought to encourage participants to describe their personal experiences of belongingness.

The interview schedule was first designed in English. However, because all of the participants were Malaysian nurses, questions were translated into Malay language by the researcher and checked by a lecturer in Bachelor in TESL in Malaysia to ensure that questions retained their original meaning. The Malay language translations of transcriptions interview were then translated back to English to ensure the meaning had not changed and was checked again by the lecturer in Bachelor in TESL in Malaysia.

4.8.1 Recruitment strategies

For the interview, the sub-sample was drawn from those nurses who had completed the questionnaires. An invitation to participate in an interview was presented at the end of the questionnaire. Participants who were interested in participating in an interview were asked to tick the column 'yes', and provide their contact details including name, contact number or email address for the researcher to make contact. This page was detached from the main page of the questionnaire and put in another pre-labelled sealed envelope provided with the title 'Belongingness survey – interview session' and sent back via internal mail to the appointed locked box in the nursing department.

A total of twenty-seven respondents agreed to participate in the interview. From each hospital, the researcher purposively selected seven nurses with different years of work experience. The years of experience ranged from none to six months, six to 12 months, one to two years, two to three years, three to four years, four to five years, and five years and above. Only one nurse was selected to represent each category. This gave a total of 14 participants across the two selected hospitals. A note at the end of the agreement to take part in the interview form advised applicants that, if the nurses who offered to participate in the interview session did not receive any feedback from the researcher within two weeks from the time they sent their questionnaire and application form, it meant that other interested nurses who had the same years of work experience and were also interested to be interviewed had been purposefully selected. The participants were purposely selected according to their years of experience, as it was considered that they would be knowledgeable about belongingness according to their involvement and experience in the clinical workplace.

4.8.2 The interview process

Arrangements were made for the interview session at a time and place that was convenient to each participant. Most participants chose to conduct their interview within the hospital area where they worked. As a result, all interviews were conducted in the hospital area, close to the participants' workplaces. All interviews were conducted in closed rooms to avoid any disturbance during the interview session, and also to provide privacy and comfort, and reduced noise. Prior to the interview, all nurses provided written consent (Appendix 6). The interviews were conducted in Malay language, audio-recorded and later transcribed verbatim. Interviews lasted between 30 and 40 minutes.

Even though participation in the interview was based on the participants' willingness to share their knowledge and experience about belongingness, some participants seemed to be very careful of what they said. Most of the time for this type of participant, prompts were used to further elicit their perspectives; for example: 'Can you describe more about that?', 'Can you share your feelings with me?' and 'Can you give an example?'

4.8.3 Transcription processes

Participant interviews which had been audio-recorded were transcribed verbatim into typed text using Microsoft Word©. The interviews were conducted in the Malay language; therefore, the original transcripts were in the Malay language. The transcriptions were translated subsequently into English by the researcher and checked by a lecturer in Bachelor in TESL in Malaysia. Because the lecturer in TESL was not from a medical background, thorough discussions were conducted through conversations by telephone or e-mail between her and the researcher where confirmation of points was required. This stage of translation was important to ensure that sentences from the transcript retained the participants' original meaning. Once

verified, the transcripts were numerically coded and pseudonyms were inserted to protect the participants' privacy and confidentiality. The transcripts were then re-read and names were removed to protect identities. The transcripts were then re-read again to ensure clarity and understanding. Line numbers were added to ensure that the quotations used in the thesis could be easily re-located in the original transcripts.

4.8.4 Thematic analysis

Thematic analysis was used to analyse qualitative data obtained from the semi-structured interviews. This is a method for identifying, analysing, and reporting patterns (themes) within data which reports experiences, meanings, and also for reflecting the reality of participants or to unravel the surface of reality (Braun & Clarke, 2006). According to Braun and Clarke (2006), a point from the interview counts as a theme when it captures something important that relates to the research question, and represents some level of patterned response or meaning within the data set. These authors further contend that the importance of a theme is not necessarily dependent on quantifiable measures, but rather on whether it captures something important in relation to the overall research question. Because thematic analysis is flexible, it allows the researcher to determine meaningful themes in a number of ways rather than trying to convince the reader by suggesting a theme really existed in the data by providing a quantified measure like 'the majority of participants' (Meehan, Vermeer, & Windsor, 2000), 'many participants' (Taylor & Ussher, 2001), or 'a number of participants' (Braun, Gavey, & McPhillips, 2003).

Thematic analysis relies on: i)'similarity principles', which involves looking for information with similar content, symbols, or meanings, and ii) 'contrast principles' which provide guidance to establish how content or symbols differ from other content or symbols (Polit & Beck, 2012). According to Polit and Beck (2012), the relationships within the data must be

distinguished between: i) ideas that apply to all or many participants or certain types of people, and ideas that are unique to a particular participant only, ii) the way the ideas are patterned; for example, are the ideas applied only in certain contexts or periods? iii) conditions that precede the phenomenon and the apparent consequences of them. By doing so, researchers are able to understand those aspects of experience occurring not only as individual units of meaning, but meanings "formed by the confluence of meanings within individual accounts" (Ayres, Kavanagh, & Knafl, 2003, p. 873).

Multiple readings of the transcript have been suggested as crucial in order to understand the phenomenon under investigation. Saldana (2009) and Braun and Clarke (2006) recommended that the transcripts should be read repeatedly line-by-line to identify specific meanings to be documented. In this study, statements or phrases that seemed essential to the experience under study were highlighted. Every sentence was analysed and important points coded that became the objects of reflection to later develop essential themes. Those specific meaningful segments of data were placed in brackets to make it clear where each segment started and ended. After multiple readings and re-readings, and reflecting on the participants' statements, significant sections were then coded with codes, categories, and themes. A concept map was used to further explore the relations between belongingness with the codes, categories and themes. Personnel notes were added at the site of the participants' statements as reminders that reflect on developing perspectives. These notes and participant segments were again re-visited and re-read as the themes started to emerge.

4.9 Trustworthiness

Qualitative research provides a valuable source of evidence to enhance nursing practice. However, the issue of trustworthiness needs to be considered prior to deciding whether the findings are an "authentic reflection" of the personal or lived experiences around the

phenomenon under investigation (Curtin & Fossey, 2007). It has been suggested that establishing the trustworthiness of qualitative research "increases the reader's confidence that the findings are worthy of attention" (Law, 2002, p. 337). For the trustworthiness of a qualitative research study to be transparent, Krefting (1991) argues that researchers need to clearly describe the strategies they used within their study. This requires the researcher to provide a rationale for the chosen method, clarify the research process, fully document the methods of data gathering, provide detail of the raw data generated, and, finally, to specify the analysis process undertaken (Higgs, 2001). In the current study, the issues mentioned above were closely adhered to. Guba and Lincoln (1985) proposed four criteria including: i) credibility, ii) transferability, iii) dependability, and iv) confirmability to determine the trustworthiness of qualitative inquiry.

4.9.1 Credibility

In addressing credibility, researchers attempt to demonstrate that a true picture of the phenomenon under scrutiny is being presented (Shenton, 2004) in which, readers, when confronted with the experience, can recognise it as plausible (Guba & Lincoln, 1985). In the current study, I initially invited participants to reflect on situations "when you sense that you belong to the workplace… when you sense that you did not belong to the workplace… or, what makes you feel happy or frustrated in the workplace". To guard against potential bias, two independent researchers, both the student's supervisors of the study, verified emerging themes and categories generated. This checking of themes enhanced the credibility of the data and ensured these were not shadowed by my own emotions or perceptions.

Participants in this current study were purposively selected according to their years of experience. From the application to take part in the interview session, one nurse from each group who had the same years of experience was selected. However, it is possible that quiet,

uncooperative or inarticulate individuals may be selected (Shenton, 2004). In the current study, participants who were a bit quiet or very selective with what they said were prompted in the interviews with questions such as: “Can you elaborate more on what you are saying… or can you give an example…” Another important way of increasing the credibility of qualitative research is through member checking (Lincoln & Guba, 1985). The current study utilised member checking. Member checking took place throughout interviews as the interviewer fed ideas back to the participants to refine, rephrase, and interpret. Participants were sent a copy of their edited transcript to provide opportunities to check that what was written paralleled their meaning and reflected their own experiences. All participants agreed with the edited transcripts.

Another attempt used to enhance the credibility of qualitative method is triangulation. Triangulation refers to the application and combination of several methods with which researchers hope to overcome weakness or intrinsic biases and problems that come from a single method, single observer, or single theory studies (Bogdan & Biklen, 2006). The idea of triangulation is that one can have more confidence in a result if different methods lead to the same result. If an investigator uses only one method, the temptation is to strongly believe in the findings. If an investigator uses two methods or locations, the results may well clash. By using two or more methods or locations, the hope is that two of the three or more will produce similar answers, or if three clashing answers are produced, the investigator knows that the question needs to be reframed, methods reconsidered, or both (Cheng, 2005). In the current study, triangulation was achieved by inviting participants from two different hospitals, from multiple workplaces, and from multiple years of experience. By doing this, individual viewpoints and experiences could be verified against others and, ultimately, a rich picture of the belongingness concept could be constructed based on the contributions of a range of

nurses. Where similar results emerged at different sites, findings may have greater credibility in the eyes of the reader.

According to Shenton (2004), establishing good rapport in the opening moments of an interview and ensuring participants' rights is essential before the data collection is started. In the current study, each participant was given the opportunity to refuse to participate. If they wanted to take part in the interview, participants received clear explanations from the researcher that they had the right to withdraw from the study at any point, and, if they did, they would not be asked to provide any explanation to the researcher. This process helps to ensure that the data collection sessions involves only those who are genuinely willing to take part and prepared to offer data freely. Each participant was encouraged to be frank from the outset of each session, indicating that there were no right answers to the questions that would be asked. Participants could, therefore, contribute ideas and talk about their experiences without fear of losing credibility in the eyes of their managers.

4.9.2 Transferability

To allow for transferability of findings, researchers provide sufficient detail of the context of the fieldwork for a reader to be able to decide whether the prevailing environment is similar to another situation with which she/he is familiar and whether the findings can justifiably be applied to the other setting, or to a wider population (Shenton, 2004). It has been argued that, since the findings of qualitative research are usually specific to a small number of particular environments and individuals, it is impossible to apply them to other situations and populations (Merriam, 2009). However, Bassey (1981) proposed that, if practitioners believe their situations to be similar to those described in a study, they may relate the findings to their own positions. Firestone (1993) and Lincoln and Guba (1985) suggest that researchers need to ensure that sufficient contextual information about the fieldwork site is provided to enable the

reader to make such a transfer. Therefore, information on the numbers and backgrounds of the hospitals taking part in the study, inclusion and exclusion criteria of the participants, the data collection methods used, the number and length of the data collection sessions and the time period over which the data were collected have been described in the current study to provide a detailed backdrop for the reader and to allow the study's transferability to be determined.

4.9.3 Dependability

Dependability refers to "the coherence of the internal process and the way the researcher accounts for changing conditions in the phenomena" (Bradley, 1993, p. 437). The meeting of dependability as a criterion is difficult in qualitative work, although researchers should at least strive to enable a future investigator to repeat the study (Shenton, 2004). In order to address the dependability issue, Guba and Lincoln (1985) suggest, the process within the study should be reported in detail, which requires in-depth methodological description, thereby enabling future research to repeat the work. Other researchers should be able to arrive at the same or similar conclusions (Lincoln & Guba, 1985). In order to enable readers of the study to develop a thorough understanding of the methods and their effectiveness, the study should describe the research design and its implementation, the operational detail of data gathering, and reflective appraisal of the project (Shenton, 2004). Therefore, in the current study, the research design has been described in detail.

4.9.4 Confirmability

To achieve confirmability, researchers must take steps to demonstrate that findings are the results of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher (Shenton, 2004). Guba and Lincoln (1985) suggest that an "audit trail" needs to be established which allows any observer to trace the course of the research step-by-step via the decisions made and procedures described. It is also important for the

researcher to develop self-awareness to avoid the influence of his or her own personal experiences. A journal, maintained throughout the current study to record my own reflections, questions, and perceptions, guided me to reflect on participants' own accounts and not on my own experiences, and I made every effort to ensure that upon analysis, it is the participants' perspectives that dominate the analytic and interpretive phase.

4.10 Ethical Considerations

Ethical considerations are important whenever the collection of data involves human beings. The main ethical issues to be considered include physical and psychological harm, deception, informed consent, and privacy (Neuman, 2011). Firstly, in terms of physical harm, the possibility of such harm to respondents is unlikely to occur in social science research as the scope of the research rarely involves the use of unsafe equipment (Neuman, 2011). As the current study involved the use of a pencil and paper survey and voice recorder for the interview, there was no possibility of physical harm to respondents.

In terms of psychological harm, there may be minimal inconvenience and/or discomfort for the study participants relating to the time required to complete the survey or participate in an interview. The semi-structured questions in the interview may have made the participants feel uncomfortable because they were being asked questions regarding their experience of belongingness in their workplace. Employees who were dissatisfied with the workplace or have had negative experiences in the workplace might feel uncomfortable about discussing their experiences, as this may cause discomfort or distress. Participants expressing distress were to be asked if they wished to continue the interview. The interview was to be abandoned if a participant requested this. This study did not anticipate any serious events or emergencies would occur during data collection. However, one senior nursing lecturer, as well as the

researcher and supervisors, was appointed to give counselling, if any participant became distressed during data collection or at some time afterwards. Data collection proceeded smoothly without incident. No participant became distressed, or requested that the interview be terminated or expressed concern after the interview.

Secondly, an ethical research project should not deceive participants. Deception occurs whenever the researcher misleads participants. This would have a negative impact, as deception creates mistrust and affects the validity of the results (Polit & Beck, 2012). In order to protect the participants from any deceptive practice, the current study explicitly revealed the purpose of the study through presentation and explanatory statement, along with the names of the researcher, the researcher's supervisors and the organisation with which the researcher is affiliated. Thirdly, the ethical considerations deal with participants' consent. Participation in the study was on a voluntary basis. The principle of voluntary participation means that individuals are not coerced into participating in the research (Trochim, 2006). No individual was coerced into participating.

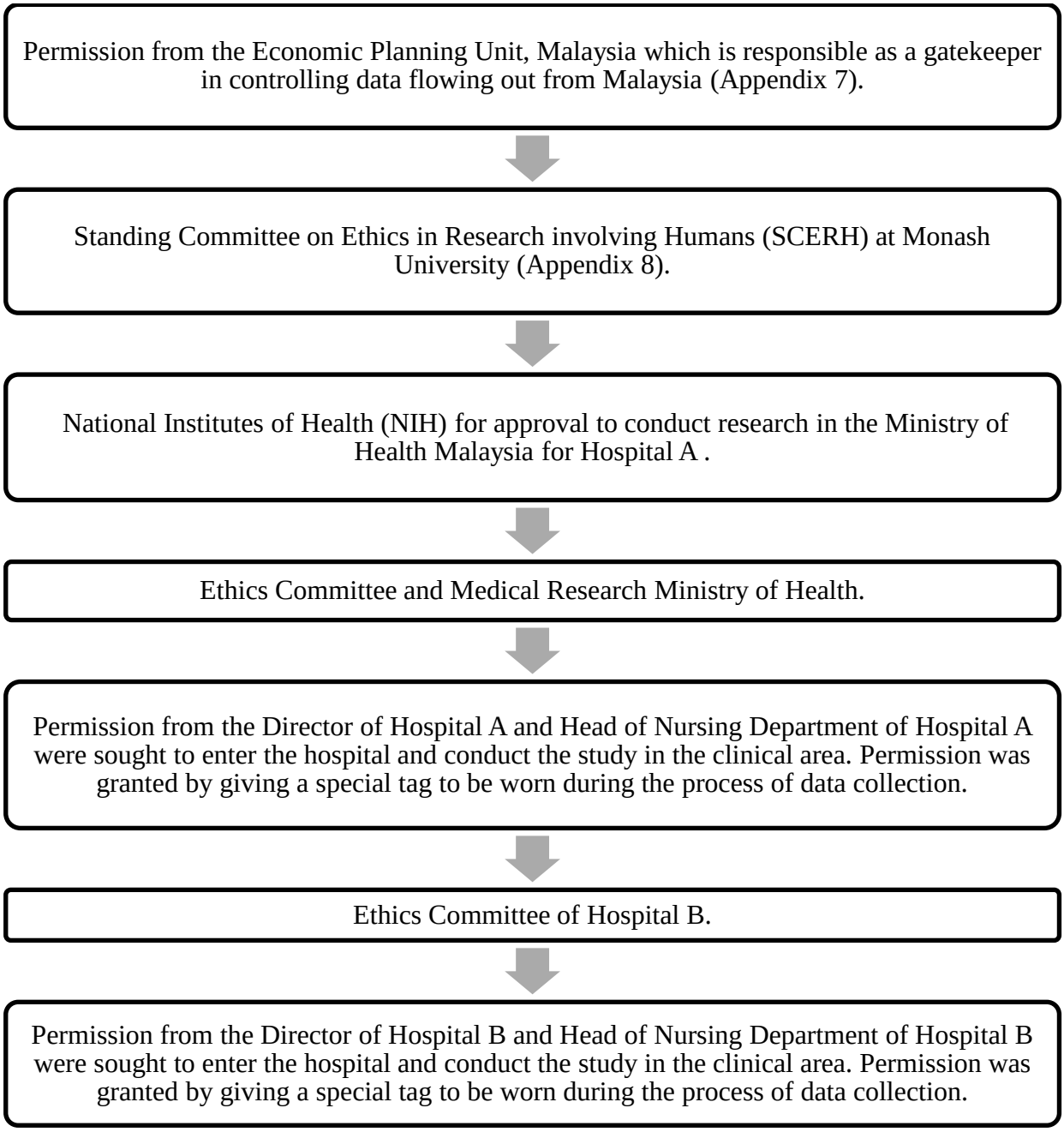
All participants in the current study were employees over 18 years of age. Thus, they had the right to volunteer their involvement in the study without parental or guardian consent, had the right to participate or not, and were able to withdraw at any stage of the study. Furthermore, when the respondents returned their completed questionnaires, the action implied their consent to participate in the study (Polit & Beck, 2012). However, informed consent (Appendix 6) was obtained from respondents who participated in the qualitative interview. The researcher clearly informed participants that their participation in the study was voluntary, and that they could withdraw at any time if they felt uncomfortable. Participants must clearly understand and be aware of what participation involves. Participants completed the consent form in writing and handed it to the researcher before the interview was

commenced. Adequate time was provided for questions to be asked and answered, both before and after the interview session. Permission was sought once again from the participants to audio record the interviews.

Lastly, to protect the privacy of research participants, confidentiality and anonymity safeguards need to be applied (Polit & Beck, 2012). The information provided in the survey was treated confidentially and remains anonymous. For the qualitative data, all participants' transcripts were coded and each was given a pseudonym. Names of people or organisations arising in the interviews were removed and not reported. Polit and Beck (2008) claim that anonymity is the most secure means of protecting confidentiality. It occurs when even the researcher cannot link participants to their data and this was true for this study. The information was used for the aims of the research and not for any other purpose. Contact details of the researcher and the institution at which the researcher was enrolled were provided for any enquiries arising during the study. The data collected is stored in a locked filing cabinet and on a password-secured computer by the researchers in the School of Nursing and Midwifery at Monash University. Only the researcher and her supervisors have access to this data. Data will be stored for five years following collection as per Monash University regulations. At the end of this period, hard copy data will be shredded and computer-based data will be permanently deleted from the hard drive of the password-secured computer where it has been stored.

As the researcher studied at Monash University and the current study was conducted in Malaysia, ethical approval involved several steps. In each step, different application forms and different paperwork were used. The steps obtained in the ethical process are shown in Figure 4.2.

Figure 4.2: The ethical process



4.11 Summary of the chapter

A mixed-methods approach utilising a questionnaire and in-depth, face-to-face semi-structured interview shaped the foundation for the current study on understanding belongingness in nursing practice. In this chapter, the processes for collecting data and the

instruments used for both quantitative and qualitative phases have been outlined. An overview of the theoretical perspective of pragmatism was provided as well as a rationale for its selection for this study. The statistical tests used to analyse the quantitative data and the interpretation of the transcripts from the qualitative phase through phenomenological lenses underpinned by Van Manen were justified. Ethical considerations involved in conducting the study were also included. In the next chapter, the data generated through the quantitative phase is reported.

Chapter Five: Quantitative Results

5.1 Introduction

The research design outlined in Chapter Four provided a background to the subsequent data analysis. In this chapter, findings from the quantitative phase using questionnaires are presented. It begins with the response rate and follows with respondents' demographic characteristics, nurses' experiences of belongingness concept in the workplace, and associations between belongingness and intrinsic feelings. Lastly, there is an examination of the strategies reported as practised by respondents to fit in with colleagues and other health care team members in the clinical workplace.

5.2 Sample

Questionnaires were distributed to all nurses working in the clinical area and involved with continuous nursing care for inpatients at Hospitals A and B. At the time of the study, Hospital A had 2594 Registered Staff Nurses (RSNs) and Hospital B had 1255 Registered Staff Nurses (RSNs). However, 393 RSNs from Hospital A and 140 RSNs from Hospital B were not engaged in providing continuous nursing care to inpatients, and therefore were excluded from receiving the questionnaire. From the 2201 RSNs at Hospital A, 268 completed questionnaires were returned, giving a total response rate of 12.2 per cent at that site. A slightly higher response was obtained at Hospital B with 169 completed questionnaires returned from 1115 RSNs, giving a total response rate of 15.2 per cent there. Total responses from across both hospitals were 437 out a total of 3316 RSNs who met the inclusions criteria, which gave an overall response rate of 13.2 per cent.

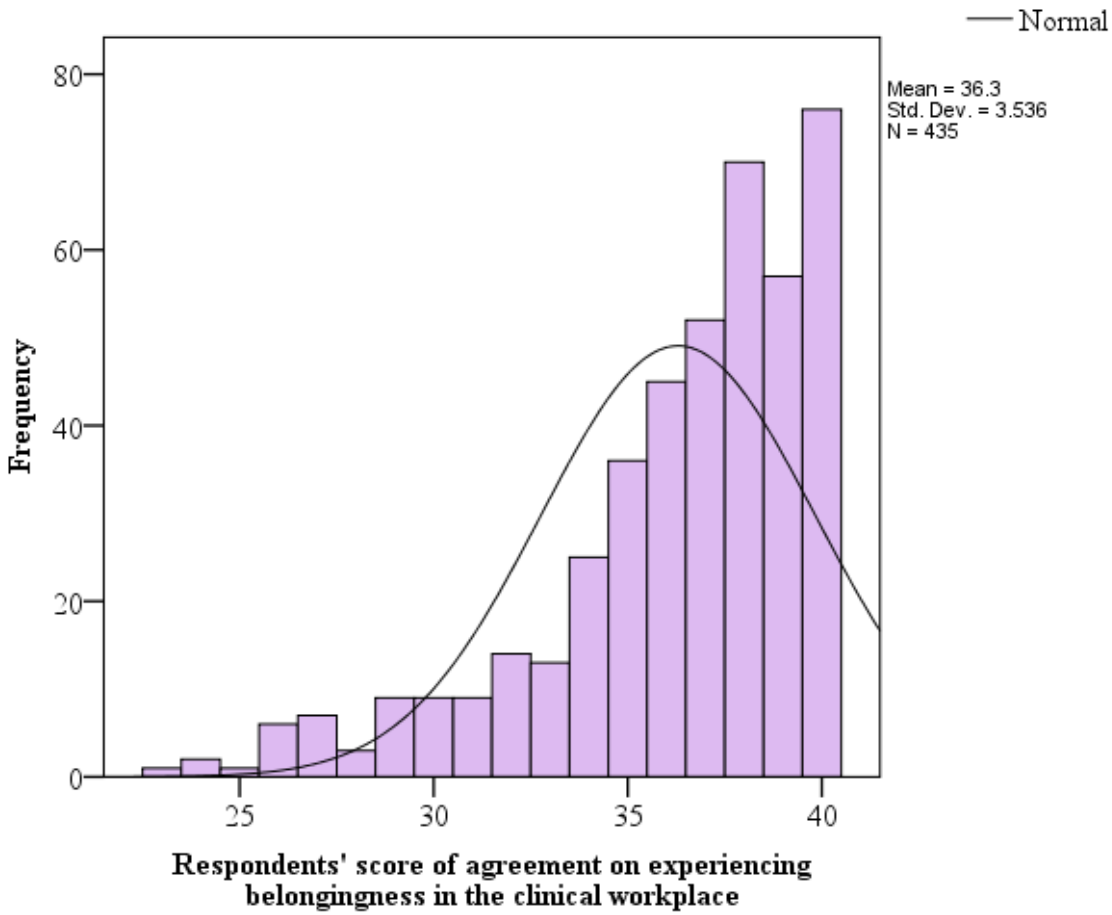
It has been suggested that the success of response to a survey depends to a great extent on the way eligible subjects are approached, and on the time, health, and moods of the subjects. In their series of gerontological surveys of a population of the oldest elderly people living in the town of Leiden, the Netherlands, Wiel et al. (2002) found that the more distracted the subjects' moods, the less likely they were to take part in data collection. In the current study, the fasting month of Ramadhan and Eid-Fitri festive season occurred during the data collection and were likely contributors to a lower than expected response rate. In Malaysia, during these seasons, most nursing staff will take turns in accessing their annual leave to spend time celebrating Ramadhan and Eid-Fitri with their families and relatives. The tradition of taking annual leave during Ramadhan and Eid-Fitri is very popular among Malaysian nurses as, by nature of nursing duties, they work shifts, including on weekends and public holidays. Data collection was scheduled a month before the arrival of the fasting month; however, due to unanticipated complicating procedures with ethical approval committees from both hospitals, data collection started two weeks after the fasting month had begun, which meant it was two weeks before the month of Eid-Fitri festive celebration. Despite this, the sample size was calculated to be representative of the population with 5% standard error and 95% confidence level. The required sample size estimated by power analysis was 344 subjects. Therefore, the sample size was considered satisfactory to conduct required testing and analysis.

5.3 Assessing normality of belongingness scores

Data distributions were assessed using Explore analysis for confirmation of normality. This analysis was important since this study involved total scores of feelings and behaviours, which, in certain circumstances, will not give a fit of normal distribution (Pallant, 2007). Out of 40 questions measuring belongingness experiences in the clinical workplace, the mean of respondents' score of agreement on experiencing belongingness in the clinical workplace was

36.19 compared to 36.60 of the 5% trimmed mean. The difference between these two mean values was 0.41, which indicates that the extreme scores were having some influence on the mean. A significance value of 0.000 from a Kolmogorov-Smirnov test suggested violation of the assumption of normality. This significance value was further supported by the histogram distributions (Figure 5.1). Data from the chart were negatively skewed which indicates the mean value was smaller than the median or mode due to a few low scores.

Figure 5.1: Normality of belongingness score in the clinical workplace.



Nine scores were considered as outliers with two of them being extreme points. The questionnaire answer sheets of the outlier candidates were checked and compared to confirm there were no errors during data entry into SPSS. The demographic characteristics of the two extreme outlier respondents were then checked to see if they were the only respondents who represented certain demographic characteristics; for example, ethnicity, age, gender or years of experience. After thorough examination, it was found that they did not come from any specific demographic characteristic group with only a few respondents representing the group; for example i) ethnicity, where only one Indian respondent came from Hospital B or, ii) gender, where only 13 male respondents came from both hospitals with only one respondent coming from Hospital B or, iii) age, where only three respondents with ages more than 40 years old came from Hospital B. Therefore, the two extreme outlier respondents from Hospital A were excluded from the correlation analysis between belongingness score and intrinsic feelings as they were not reflecting what was most true for most respondents who had the same demographic characteristics. The other seven outliers were included in the correlation analysis as they were not considered so extreme. Exclusion of the two extreme outliers decreased the total respondents from Hospital A to 266 respondents. Therefore, the total of respondents from Hospital A was 266, while Hospital B respondents were maintained at 169 which made the overall total of respondents from both hospitals was reduced to 435 (for the purpose of correlation analysis in Section 5.6 only). No alteration was made in total respondents for any other SPSS analysis.

5.4 Demographic Characteristics of Respondents

Respondents were recruited from two hospitals situated in Kuala Lumpur, Malaysia. A range of demographic characteristics of respondents was examined, such as gender, age, ethnicity, place of basic training, level of nursing education, and years of experiences in the clinical area. Each was analysed separately.

5.4.1 Gender

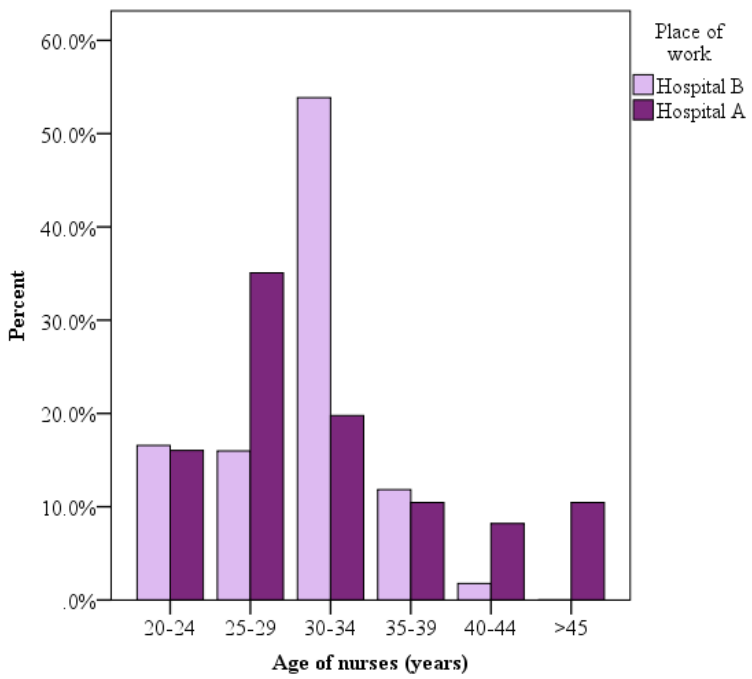
Data analysis showed that the majority of respondents (n = 424, 97.0%) were female. As mentioned earlier in Chapter One, the nursing profession in Malaysia is still dominated by female nurses. This statistic explains why the ratio between male and female nurses was vastly different in this study. The thirteen male nurse respondents in this study represented 2% of the overall total male registered nurses working in Malaysia's hospitals. Of these 13 respondents, 12 were working at Hospital A, and one worked at Hospital B. A Chi-Square test for independence (with Yates Continuity Correction) indicated a significant association between gender and place of work, χ^2 (1, n = 437) = 4.1, p = 0.04, phi = - 0.111. However, the phi coefficient value of - 0.111, is considered as having only a small effect on this relationship (Cohen, 1988).

This distribution of gender across the hospitals might be due to the fact that Hospital A operated under the Ministry of Health and had links to other hospitals and schools of nursing, all under the Ministry of Health. Hospital B, on the other hand, did not have other branches of hospital or schools of nursing. As a single-sited school, Hospital B's intake of nursing candidates is not as diverse as Hospital A's. In Malaysia, newly graduated nurses are often bonded to the Ministry of Health or a private hospital for a period of time following their initial preparation, in recognition of the employer's contribution to the cost of their education. If they use their own funds to support their initial education, new graduates are not bonded to any institution and are free to work in any hospital of their choice. To compound the effect of limited places being offered by Hospital B's school of nursing, the influence of the stereotypical perspective of nursing as a gendered profession also limits the application of male candidates into nursing courses.

5.4.2 Age

Age data was obtained using categories; therefore, it is not possible to determine an exact mean age of respondents. Interestingly, the age distribution for Hospital B was dominated by respondents between the ages of 30 and 34 years. There were no respondents over the age of 45 years from Hospital B. In contrast, the age distribution for Hospital A was spread more evenly between the age groups and there was no domination of an age group. A Chi-Square test for independence indicated a significant association between age and place of work, χ^2 (1, n = 437) = 75.5, p = 0.000, phi = 0.416. The phi coefficient value of 0.416 is considered as having a medium effect on this group of respondents (Cohen, 1988). This different distribution of age groups might be due to the years of establishment of the two hospitals; as previously indicated Hospital B started to operate in 1997, with the majority of the nursing staff newly graduated nurses aged between 20 to 25, while Hospital A started its operation in 1870. Figure 5.2 shows respondents' age distribution for both hospitals.

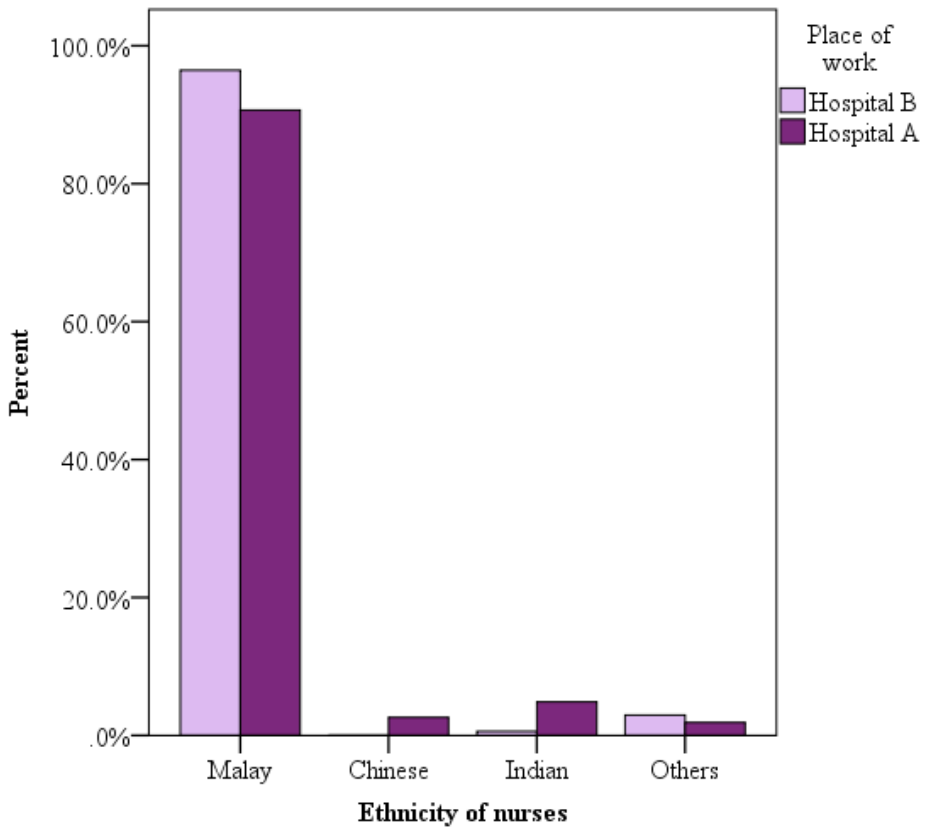
Figure 5.2: Age distribution across hospitals.



5.4.3 Ethnicity

As mentioned previously in Chapter One, Malaysia is a multi-cultural country. In the Malaysian nursing population, there were 48,930 nurses of Malay ethnicity, 1,730 of Chinese ethnicity, 1,894 of Indian ethnicity, and 10,588 from other Malaysian indigenous ethnicities (S. Safiah, personal communication, August 29, 2012). In the current study, the majority (n = 406, 92.9%) of nurses who participated were Malaysian nationals of Malay ethnicity. A Chi-Square test for independence indicated a significant association between ethnicity and place of work for Hospitals A and B, χ^2 (1, n = 437) = 11.19, p = 0.011, phi = 0.160. However, this significance is only of a small effect as the phi coefficient value was 0.160 (Cohen, 1988). Figure 5.3 shows ethnicity distribution of respondents for both hospitals.

Figure 5.3: Ethnicity across hospitals.



5.4.4 Place of basic nursing education

As discussed in Chapter One, staff nurses in Malaysia are educated in schools of nursing run by the Ministry of Health, Ministry of Higher Education or private organisations. The place of basic training for respondents at Hospital A was dominated by those trained by the School of Nursing under the Ministry of Health (n = 251, 93.3%). Even though the School of Nursing under the Ministry of Higher Education educated the majority of Hospital B respondents, distributions were more even, with almost half of respondents educated by other schools of nursing. A Chi-Square test for independence indicated a significant association between place of basic training and place of work, χ^2 (1, n = 437) = 228.9, p = 0.000, phi = 0.724.

The phi coefficient value of 0.724 is considered as having a large effect for this group of respondents (Cohen, 1988). This indicates that there was a strong association between place of basic nursing education and place of work. Most nurses who were educated under the Ministry of Health would probably continue their service with public hospitals operated under the Ministry of Health, which has links to other hospitals and clinics under the Ministry of Health all over Malaysia. Even though Hospital B had its own nursing college that operated under the Ministry of Higher Education, and most nurses educated there would probably continue their service with Hospital B, the numbers of nursing graduates produced by Hospital B's nursing college were limited. Therefore, Hospital B needed to offer places and receive graduates from other schools of nursing to maintain its workforce requirements. In Malaysia, nursing graduates educated under the Ministry of Higher Education will usually work with the university's hospital unless the university does not have its own teaching hospital or the candidates are not bound to the university where they graduated.

5.4.5 Level of nursing education

Analysis revealed that the majority of respondents (*n*=422, 96.6%) from both hospitals listed diploma holder as their highest level of education. As mentioned earlier in Chapter One, the Diploma in Nursing is the most basic nursing qualification in Malaysia, which enables a new graduate to practise as a Registered Staff Nurse. A Chi-Square test for independence (with Yates Continuity Correction) indicated there was no significant association between highest level of nursing education and respondents' place of work, χ^2 (1, n = 437) = 2.12, p = 0.145, phi = - 0.08. This means that the proportion of respondents according to level of nursing education who worked at Hospital A was not significantly different from the proportion of respondents according to level of nursing education who worked at Hospital B. As the diploma level is still considered to be the benchmark for the Malaysian nursing profession, enabling them to work as Registered Staff Nurses in clinical areas, it is very rare to see degree-holding nurses staying and continuing their employment as staff nurses in clinical areas. They usually seek better salaries in the private sector or in management or academia. Table 5.1 presents a summary of respondents' demographic characteristics, including gender, place of basic nurse training and level of education according to their places of work.

Table 5.1: Gender, place of training and education level across hospitals.

Demographic	**Hospital A N = 268**	**%**	**Hospital B N = 169**	**%**
Gender				
Male	12	4.5	1	0.6
Female	256	95.5	168	99.4
Place of Training				
Ministry of Health	251	93.6	47	27.8
Ministry of Higher Education	8	3	119	70.4
Other	9	3.4	3	1.8
Level of Education				
Diploma	262	97.8	160	94.7
Bachelor Degree	6	2.2	9	5.3

5.4.6 Years of experiences in clinical area

Respondents' years of experience were obtained using categories; therefore, it is not possible to calculate the exact mean years of nursing experience for respondents. The majority of respondents from both Hospital A (n = 141, 52.4%) and Hospital B (n = 113, 66.9%) had more than five years' work experience since graduating from their basic nursing course. Respondents with more than five years of work in the same clinical area were also found to dominate the distribution for both Hospital A (n = 109, 40.5%) and Hospital B (n = 77, 45.6%). However, the data also showed that there was some movement of respondents around the clinical area (Table 5.2 and 5.3). This suggests that the reshuffle of staff since their first clinical placement after graduating from basic nursing education could happen at any time in both hospitals. This might be because either the respondents had been promoted to other nursing positions at a different clinical area, or had been moved to other clinical areas or other hospitals. Relocation of staff is usually undertaken by nursing management in response to direct requests from individual staff members or other management factors.

Table 5.2: Respondents' movements of workplace since graduating for Hospital A.

Years of experience	Since graduating	In current clinical area	Numbers of movements
< 6 months	14	18	4
6 months – 1 year	16	22	6
1.1 – 2 years	31	49	18
2.1 – 3 years	25	26	1
3.1 – 4 years	29	32	3
4.1 – 5 years	12	12	0
> 5 years	141	109	32
Total respondents	**268**	**268**	**64**

Table 5.3: Respondents' movements of workplace since graduating for Hospital B.

Years of experience	Since graduating	In current clinical area	Numbers of movements
< 6 months	6	15	9
6 months – 1 year	6	10	4
1.1 – 2 years	10	23	13
2.1 – 3 years	14	20	6
3.1 – 4 years	11	17	6
4.1 – 5 years	9	7	2
> 5 years	113	77	36
Total respondents	**169**	**169**	**76**

A Chi-Square test for independence indicated no significant association between years of experience since graduation from basic nursing and place of work, χ^2 (1, n = 437) = 11.37, p = 0.077, phi = -0.161. There was also no significant association between years of experience in the current clinical area and the place of work, χ^2 (1, n = 437) = 4.142, p = 0.657, phi = -0.097. This indicates that the proportion of respondents who worked at Hospital A according to years of experience since basic training or to the current clinical area was not significantly different from the proportion of respondents who worked at Hospital B according to years of experience since graduating from basic nursing or to the current clinical area. Figure 5.4 shows respondents' years of nursing experience since graduating from basic nursing, while Figure 5.5 shows respondents' years of nursing experience in their current clinical area. Table 5.4 presents a summary of respondents' demographic characteristics and their places of work.

Figure 5.4: Experience since graduation across hospitals

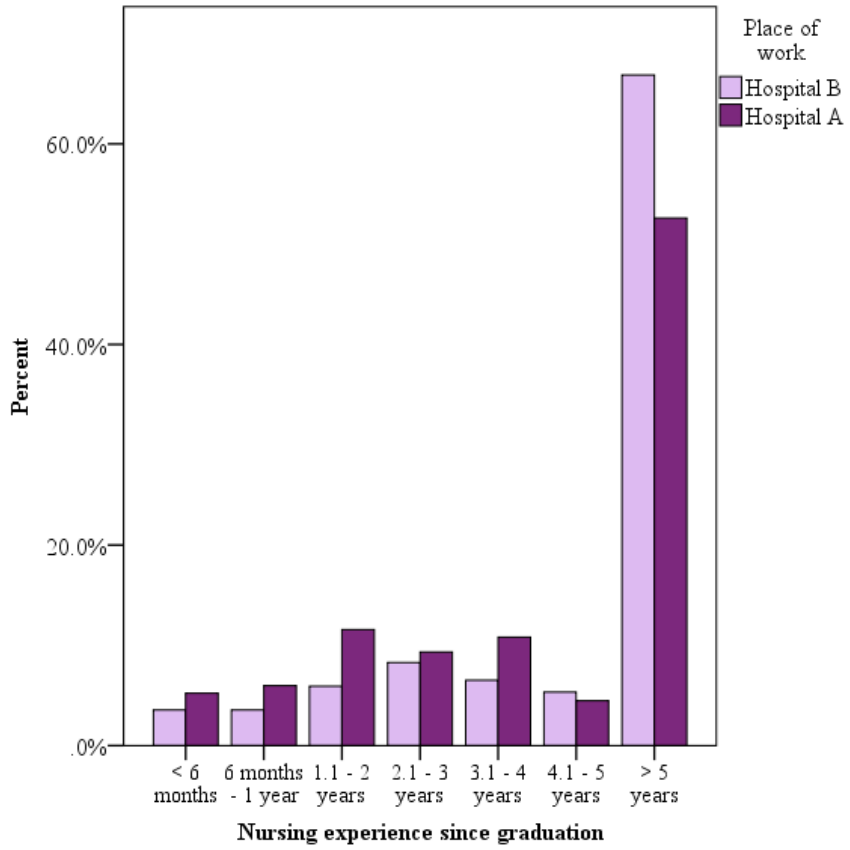


Figure 5.5: Experience in current clinical area across hospitals

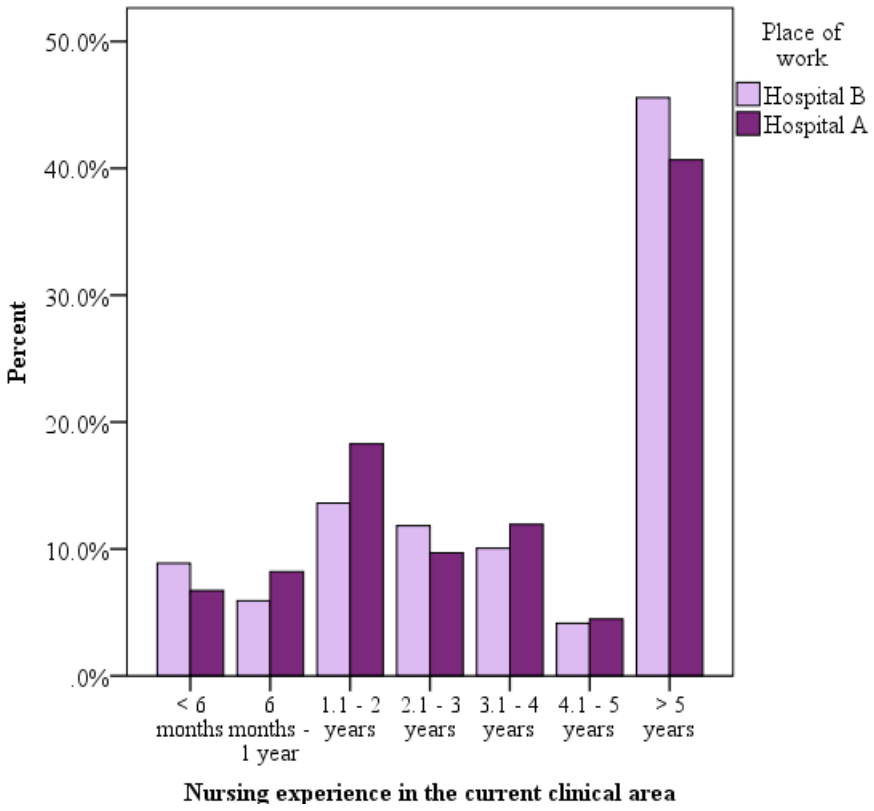


Table 5.4: Demographic characteristics versus place of work (Hospital A and B, n = 437)

Characteristics	*p* value
Gender versus place of work.	0.04*
Age versus place of work.	0.000*
Ethnicity versus place of work.	0.011*
Place of basic training versus place of work.	0.000*
Level of nursing education versus place of work.	0.145
Years of experience since graduating from basic nursing versus place of work.	0.077
Years of experience in the current clinical area versus place of work.	0.657

*$p < 0.05$ (2-tailed)

5.5 Belongingness experience in the clinical workplace

In this section, analysis of respondents' perceptions of their levels of belongingness in the workplace is presented. This analysis addresses research question number one: "To what extent do nurses experience the concept of belongingness in the workplace with colleagues, other health care team members, and the organisation?" Respondents were asked to indicate their level of belongingness on a Likert scale ranging from strongly disagree (1) to strongly agree (4). Findings are reported under the following three main headings: Belongingness experience with colleagues, Belongingness experience with other health care team members and Belongingness experience with the organisation.

5.5.1 Belongingness experience with colleagues

The highest scoring item was question number two: *"It is important to feel accepted by my colleagues"* (M = 3.52, SD = 0.514). A mean score of 3.52 indicates that almost all (n = 434, 99.3%) respondents either agreed (*n* = 205, 46.9%) or strongly agreed (*n* = 229, 52.4%). This finding indicates that feeling accepted by colleagues was viewed by the nurses as an important element in experiencing belongingness at the workplace. As well as feeling accepted, maintaining the acceptance that the nurses had already received from colleagues was viewed as another important element of belonging (M = 3.42, SD = 0.521). The mean score of 3.42 indicates that almost all (n = 431, 98.6%) of the nurses selected either agreed (n = 242, 55.4%) or strongly agreed (n = 189, 43.2%) in response to this item.

Respondents also reported liking their current clinical workplace (M = 3.38, SD = 0.548), which indicates that almost all (n = 423, 96.8%) had no problems adjusting themselves to their colleagues and clinical surroundings. Two hundred and forty-three (56.6%) agreed and

180 (41.2%) strongly agreed. In parallel with this result, item number 11, *"I do not feel discriminated against by my colleagues at my clinical workplace*" had a mean score of 3.03 (SD = 0.733). A mean score of 3.03 indicates that almost all (n = 355, 81.2%) either agreed (n = 244, 55.8%) or strongly agreed (n = 111, 25.4%). In response to item number seven, *"I view my clinical workplace as a place to experience a sense of belonging"*, the majority (n = 398, 91.0%) of respondents either agreed (n = 272, 62.2%) or strongly agreed (n = 126, 28.8%). This indicated that nurses in this study perceived that their clinical workplace as a place that should possess a sense of belonging. In line with this result, item number 16, "*feeling 'a part of things' is one of the things I like about working in the clinical area"* had a mean score of 3.22 (SD = 0.493). A mean score of 3.22 indicates that almost all (n = 422, 96.6%) of respondents either agreed (n = 309, 70.7%) or strongly agreed (n = 113, 25.9%). This further indicates that nurses in this study highly valued sense of belonging and how they appreciate their colleagues to involve them in activities in the clinical area.

Respondents in this study emphasised the importance of teamwork with colleagues in the clinical workplace. Item number five, "*Colleagues offer to help me when they sense I need it"* had a mean score of 3.34 (SD = 0.542) which indicates that almost all (n = 424, 97.1%) of the nurses selected either agreed (n = 262, 60%) or strongly agreed (n = 162, 37.1%) that colleagues offered help when needed. In return, respondents indicated that they also did the same thing in return to their colleagues help. Item number 12, "I *offer to help my colleagues, even if they don't ask for it"* had a mean score of 3.32 (SD = 0.490) which indicates that almost all (n = 432, 98.9%) of the nurses either agreed (n = 288, 65.9%) or strongly agreed (n = 144, 33%).

Item number 13, *"I invite colleagues to eat lunch or dinner with me*" scored the lowest (M = 2.99, SD = 0.577) of the 20 items. Even though the score of this item was the lowest, only 71

(16.3%) respondents disagreed (n = 69, 15.8%) or strongly disagreed (n = 2, 0.5%), the majority of respondents (n = 366, 83.7%) still believed that inviting their colleagues to eat lunch or dinner together during their break time would help to enhance their belongingness experience at the workplace. This might be due to either the nurses wanting to show appreciation for their colleagues' acceptance or to build strong feelings of acceptance with their colleagues. From the analyses, it can be summarised that the majority of respondents experienced a sense of belonging with their colleagues in the workplace. Table 5.5 summarises the means and standard deviations for each item of their belongingness experience scores with colleagues in the clinical workplace. This is followed by Table 5.6 which summarises the means and standard deviations according to their ranked scores.

Table 5.5: Belongingness experience in the clinical workplace with colleagues (N = 437).

	Items	Mean	SD
Q 1	I feel like I fit in with my colleagues.	3.35	0.531
Q 2	It is important to feel accepted by my colleagues.	3.52	0.514
Q 3	It is important to maintain the acceptance I received from my colleagues.	3.42	0.521
Q 4	Colleagues see me as a competent person.	3.05	0.504
Q 5	Colleagues offer to help me when they sense I need it.	3.34	0.542
Q 6	I make an effort to help new students or staff feel welcome.	3.32	0.476
Q 7	I view my clinical workplace as a place to experience a sense of belonging.	3.19	0.595
Q 8	I get support from colleagues when I need it.	3.31	0.536
Q 9	I am invited to social events outside of my clinical workplace by colleagues.	3.09	0.600
Q 10	I like working with my colleagues.	3.36	0.513
Q 11	I do not feel discriminated against by my colleagues at my clinical workplace.	3.03	0.733
Q 12	I offer to help my colleagues, even if they don't ask for it.	3.32	0.490
Q 13	I invite colleagues to eat lunch or dinner with me.	2.99	0.577
Q 14	Colleagues ask for my ideas or opinion about different matters concerning the workplace.	3.16	0.474
Q 15	I ask for my colleagues' advice about patient care.	3.34	0.498
Q 16	Feeling "a part of things" is one of the things I like about working in the clinical area.	3.22	0.493
Q 17	I like where I work in the clinical area.	3.38	0.548
Q 18	It seems that my colleagues like to work with me.	3.21	0.490
Q 19	I feel free to share my disappointments with at least one of my colleagues.	3.19	0.567
Q 20	When I come to work, I feel welcomed by all staff.	3.12	0.462

Table 5.6: Belongingness experience in the clinical workplace with colleagues' scores ranked (N = 437).

	Items	Mean	SD
Q 2	It is important to feel accepted by my colleagues.	3.52	0.514
Q 3	It is important to maintain the acceptance I received from my colleagues.	3.42	0.521
Q 17	I like where I work in the clinical area.	3.38	0.548
Q 10	I like working with my colleagues.	3.36	0.513
Q 1	I feel like I fit in with my colleagues.	3.35	0.531
Q 5	Colleagues offer to help me when they sense I need it.	3.34	0.542
Q 15	I ask for my colleagues' advice about patient care.	3.34	0.498
Q 6	I make an effort to help new students or staff feel welcome.	3.32	0.476
Q 12	I offer to help my colleagues, even if they don't ask for it.	3.32	0.490
Q 8	I get support from colleagues when I need it.	3.31	0.536
Q 16	Feeling "a part of things" is one of the things I like about working in the clinical area.	3.22	0.493
Q 18	It seems that my colleagues like to work with me.	3.21	0.490
Q 19	I feel free to share my disappointments with at least one of my colleagues.	3.19	0.567
Q 7	I view my clinical workplace as a place to experience a sense of belongingness.	3.19	0.595
Q 14	Colleagues ask for my ideas or opinion about different matters concerning the workplace.	3.16	0.474
Q 20	When I come to work, I feel welcomed by all staff.	3.12	0.462
Q 9	I am invited to social events outside of my clinical workplace by colleagues.	3.09	0.600
Q 4	Colleagues see me as a competent person.	3.05	0.504
Q 11	I do not feel discriminated against by my colleagues at my clinical workplace.	3.03	0.733
Q 13	I invite colleagues to eat lunch or dinner with me.	2.99	0.577

5.5.2 Belongingness experience with other health care team members

Respondents scored item number two, *"It is important to feel accepted by other health care team members*" (M = 3.41, SD = 0.510) as the most important element of their belongingness experience with other health care team members. A mean score of 3.41 indicates that almost all (n = 433, 99.0%) of respondents either agreed (n = 251, 57.4%) or strongly agreed (n = 182, 41.6%). It also can be seen from the analysis that maintaining the acceptance respondents received from other health care team members (M = 3.37, SD = 0.506) was viewed as the second important element. This indicates that almost all respondents (n = 432, 98.9%) either agreed (n = 267, 61.1%) or strongly agreed (n = 165, 37.8%) as their response to this item.

Almost all respondents reported having no difficulties adjusting themselves to other health care team members. The respondents felt they fitted in well (M = 3.20, SD = 0.462) with other health care team members at their workplace. A mean score of 3.20 indicates that the majority (n = 425, 97.2%) of respondents either agreed (n = 327, 74.8%) or strongly agreed (n = 98, 22.4%). Respondents also rated their feelings of working with other health care team members as positive. Item number seven, *"I get along well with other health care team members at my workplace*" had a mean score of 3.16 (SD = 0.473). This indicates the majority (n = 420, 96.1%) felt that they got along very well with other health care team members. The majority (n = 413, 94.5%) of respondents reported having good teamwork experiences (M = 3.13, SD = 0.475) with other health care team members. The majority (n = 391, 89.5%) of respondents reported that they felt respected (M = 3.01, SD = 0.481) by other health care team members at their workplace. Even though the majority of respondents felt they sensed a good belongingness experience with other health care team members, 99 (22.7%) felt discriminated against by them with 91 (20.8%) disagreeing and 8 (1.8%) strongly disagreeing with the statement.

The majority of respondents (n = 276, 63.2%) experienced being invited to social events by other health care team members outside of their clinical area (M = 2.68, SD = 0.685). However, item number 12, *"I invite other health care team members to eat lunch or dinner with me*" scored the lowest (M = 2.52, SD = 0.686) of the 12 items. Almost half (n = 208, 47.6%) of the respondents either disagreed (n = 183, 41.9%) or strongly disagreed (n = 25, 5.7%) with this item. This response might indicate that some respondents felt under-confident or uneasy about inviting other health care team members to join them and having informal conversations with them during meal times. Table 5.7 summarises the mean and standard deviation for each item of their belongingness experience score with other health care team members in the clinical workplace. This is followed by Table 5.8 that presents means and standard deviations according to their ranked scores.

Table 5.7: Belongingness experience in the clinical workplace with other health care team members (N = 437).

	Items	Mean	SD
Q 1	I feel I fit in with other health care team members where I work.	3.20	0.462
Q 2	It is important to feel accepted by other health care team members.	3.41	0.510
Q 3	It is important to maintain the acceptance I received from other health care team members.	3.37	0.506
Q 4	Other health care team members see me as a competent person.	3.00	0.520
Q 5	I am invited to social events outside of my clinical area by other health care team members whom I work with.	2.68	0.685
Q 6	I feel respected by other health care team members where I practice.	3.01	0.481
Q 7	I get along well with other health care team members at my workplace.	3.16	0.473
Q 8	I have good teamwork with other health care team members.	3.13	0.475
Q 9	I do not feel discriminated against by other health care team members at my clinical workplace.	2.92	0.662
Q 10	I ask for advice about patient care from other health care team members.	3.17	0.431
Q 11	Other health care team members ask for my ideas or opinion about different matters concerning the workplace.	2.97	0.497
Q 12	I invite other health care team members to eat lunch or dinner with me.	2.52	0.686

Table 5.8: Belongingness experience in the clinical workplace with other health care team members scores ranked (N = 437).

	Items	Mean	SD
Q 2	It is important to feel accepted by other health care team members.	3.41	0.510
Q 3	It is important to maintain the acceptance I received from other health care team members.	3.37	0.506
Q 1	I feel I fit in with other health care team members where I work.	3.20	0.462
Q 10	I ask for advice about patient care from other health care team members.	3.17	0.431
Q 7	I get along well with other health care team members at my workplace.	3.16	0.473
Q 8	I have good teamwork with other health care team members.	3.13	0.475
Q 6	I feel respected by other health care team members where I practice.	3.01	0.481
Q 4	Other health care team members see me as a competent person.	3.00	0.520
Q 11	Other health care team members ask for my ideas or opinion about different matters concerning the workplace.	2.97	0.497
Q 9	I do not feel discriminated against by other health care team members at my clinical workplace.	2.92	0.662
Q 5	I am invited to social events outside of my clinical area by other health care team members whom I work with.	2.68	0.685
Q 12	I invite other health care team members to eat lunch or dinner with me.	2.52	0.686

5.5.3 Belongingness experience with the organisation

Reported belongingness experiences with the organisation where respondents worked obtained positive feedback as almost all (n = 406, 92.9%) felt they strongly belonged to the organisation (M = 3.08, SD = 0.475). Item number six, *"I respect the administrative people (nursing and others) in my organisation"* received the highest score (M = 3.23, SD = 0.465) of the eight items. A mean score of 3.23 indicates that almost all (n = 431, 98.6%) either agreed (n = 322, 73.7%) or strongly agreed (n = 109, 24.9%) with this statement. This scenario might indicate the influence of Malay culture in the workplace setting where higher ranking or senior staff are highly respected by their subordinates. However, even though respondents stated they respected the administrative people in their organisation, item number four, *"I get adequate opportunities (e.g. promotion, study leave) from the organisation where I work*" scored the lowest mark. One hundred and eighteen (27.0%) of them either disagreed (n = 99, 22.7%) or strongly disagreed (n = 19, 4.3%) that they had adequate opportunities from their organisation (M = 2.79, SD = 0.681). From the analysis, it was found that 85 (72.0%) respondents who felt they did not get adequate opportunities of being promoted or granted study leave were nurses who had nursing experience of more than five years after graduating from their basic nursing training. This might be due to the development of satisfaction with their expertise and the need for something different to enhance the monotony of doing the same routine in their clinical workplace. Loukidou, Loan-Clarke, and Daniels (2012) found that when people reached a maximum level of expertise and mastered the level by doing it every day, it could become a monotonous, routine task that the person found stressful for that reason alone.

The majority (n = 411, 94.0%) of respondents agreed that their organisation recognised nursing as a profession in the health care organisation (M = 3.22, SD = 0.554). Therefore, item number one, "*Being a nurse in a multidisciplinary clinical area does not make me feel*

like an outsider" accumulated a total of 326 (74.6%) of respondents either choosing to agree (61.3%, n = 268) or strongly agree (13.3%, n = 58) with the statement. Even though this item scored the second lowest mark (M = 2.84, SD = 0.692) of the eight items, it indicates that the majority of respondents actually felt comfortable with their multidisciplinary workplace. They (n = 343, 78.5%) also felt comfortable attending multidisciplinary social functions that had been organised, as they felt the nursing profession really belonged to the organisation (M = 2.99, SD = 0.712). Table 5.9 summarises the means and standard deviations for each item of their belongingness experiences score with other health care team members in the clinical workplace. This is followed by Table 5.10 that presents means and standard deviations according to their ranked scores.

Table 5.9: Belongingness experience in the clinical workplace with organisation scores (N = 437).

	Items	Mean	SD
Q 1	Being a nurse in a multidisciplinary clinical area does not make me feel like an outsider.	2.84	0.692
Q 2	As a nurse, I am comfortable attending multidisciplinary social functions at the clinical workplace, as I feel like nursing does belong.	2.99	0.712
Q 3	I feel strongly that I belong to the organisation where I work.	3.08	0.475
Q 4	I get adequate opportunities (e.g. promotion, study leave) from the organisation where I work.	2.79	0.681
Q 5	I get adequate support (e.g. preceptorship, orientation) from the organisation.	2.98	0.546
Q 6	I respect the administrative people (nursing and others) in my organisation.	3.23	0.465
Q 7	My organisation recognises nursing as a profession.	3.22	0.554
Q 8	My organisation involves nurses in decision-making.	3.04	0.595

Table 5.10: Belongingness experience in the clinical workplace with the organisation scores ranked (N = 437).

	Items	Mean	SD
Q 6	I respect the administrative people (nursing and others) in my organisation.	3.23	0.465
Q 7	My organisation recognises nursing as a profession.	3.22	0.554
Q 3	I feel strongly that I belong to the organisation where I work.	3.08	0.475
Q 8	My organisation involves nurses in decision making.	3.04	0.595
Q 2	As a nurse, I am comfortable attending multidisciplinary social functions at the clinical workplace as I feel like nursing does belong.	2.99	0.712
Q 5	I get adequate support (e.g. preceptorship, orientation) from the organisation.	2.98	0.546
Q 1	Being a nurse in a multidisciplinary clinical area does not make me feel like an outsider.	2.84	0.692
Q 4	I get adequate opportunities (e.g. promotion, study leave) from the organisation where I work.	2.79	0.681

5.6 Relationship between belongingness and intrinsic feelings

In this section, analysis of the relationship of belongingness experience (scores from Belongingness Scale tool) in the workplace with nurses' intrinsic feelings (scores from Intrinsic Feelings tool) is presented. This analysis provides answers to research question number two: "Is there any relationship between nurses' scores of belongingness experience (as measured by the total score of 40 items on the Belongingness Scale Tool) in the workplace with: i) total scores of feelings of motivation (as measured by the total score of 9 items on the

Motivation Scale), ii) total score of feelings of confidence (as measured by the total scores of 8 items on the Confidence Scale in the clinical workplace), and iii) total score of job satisfaction (as measured by the total scores of 8 items on the Job Satisfaction Scale). Does intrinsic motivation, confidence level and job satisfaction increase with belongingness experience?"

Respondents were asked to indicate their feelings of motivation, confidence and job satisfaction on a Likert scale ranging from strongly disagree (1) to strongly agree (4). To examine the relationship, total scores of belongingness experiences in the clinical workplace and total scores of feelings of motivation, feelings of confidence and job satisfaction were correlated using a parametric test. Even though the test of normality suggests abnormal distribution, due to the large sample size (n =435), the parametric test limits the bias, as a non-parametric test is more suitable for a small sample size. One important element of the Central Limit Theory is that when the sample size is large, the sampling distribution of the sample means will approach the normal curve if the population distribution is not normal (Brewer, 2001; Salkind, 2011). According to Houser (2012), a sample with less than 30 subjects is considered to be a small sample size. They are considered not powerful enough to detect changes in an outcome variable. Therefore in this study, Pearson's product-moment correlation coefficient was used to examine the relationships as it would show relationships (correlation) between belongingness scores and feelings of motivation, feelings of confidence and job satisfaction.

Analysis of overall total scores of belongingness experience revealed significant influences ($p < 0.01$) between belongingness and respondents' feelings of motivation, confidence, and job satisfaction. Among these three characteristics, feelings of confidence received the highest impact among respondents' intrinsic feelings ($r = 0.474$, $n = 435$, $p = 0.000$). This indicates

that across both hospitals, when respondents experienced a high sense of belonging in the clinical workplace, their levels of feeling confident to work in the multidisciplinary clinical workplace also increased. These effects were more significant for respondents from Hospital B when their correlation test revealed a high positive relationship between the two variables ($r = 0.614$, $n = 169$, $p = 0.000$). This indicates that Hospital B respondents' confidence levels were highly influenced by the belongingness experience they received in the clinical workplace.

In contrast, analysis from overall total scores of Hospital A respondents revealed that belongingness experience had more influence on their feelings of motivation. A moderate positive relationship ($r = 0.387$, $n = 266$, $p = 0.000$) between the two variables indicates that the higher the sense of belonging experienced by the nurses in their clinical workplace, the higher the motivation to work in the clinical workplace. However, even though feelings of motivation received the highest influence from Hospital A respondents, the other variables received almost the same impact as feeling motivated, which suggests, for Hospital A respondents, their belongingness experiences in the clinical workplace did influence their intrinsic feelings as a whole. Table 5.11 shows respondents' overall belongingness scores with their intrinsic feelings in the clinical workplace.

Table 5.11: Pearson Product-Moment correlations between belongingness scores and perceived measures of motivation, confidence level and job satisfaction.

Overall belongingness scores	Intrinsic motivation (*r*)	Confidence level (*r*)	Job satisfaction (*r*)
Hospital A + Hospital B (n=435)	0.351	0.474	0.394
Hospital A (*n* = 266)	0.387	0.381	0.342
Hospital B (*n* = 169)	0.293	0.614	0.483

r value effect (0.10 - 0.29 = small, 0.30 – 0.49 = medium, 0.50 – 1.0 = large).

To further understand the difference between the two groups, the correlation is presented according to the hospital where respondents worked. For Hospital B nurses, scores of belongingness experience with colleagues had the highest significant influence on participants feeling satisfied with their job in the clinical workplace ($r = 0.387$, $n = 169$, $p = 0.000$). This indicates the importance among Hospital B staff of maintaining harmony in working environments to promote satisfaction. On the other hand, scores of belongingness experience with colleagues had the highest significant influence on feeling confident ($r = 0.318$, $n = 266$, $p = 0.000$) for Hospital A nurses. This indicates acceptance, trust, and support from colleagues helped the Hospital A nurses to feel more confident working in the multi-disciplinary workplace.

The score for belongingness experience with other health care team members ($r = 0.520$, $n = 169$, $p = 0.000$), and the organisation ($r = 0.530$, $n = 169$, $p = 0.000$) was rated as the highest significant relationship to feeling more confident for Hospital B respondents. This suggests that acceptance, trust, and support from other health care team members and the organisation helped the Hospital B nurses to feel more confident to work in the multidisciplinary workplace. Parallel to Hospital B findings, the correlation analysis between belongingness

experiences with other health care team members for Hospital A respondents indicated a higher influence on feeling more confident. Results of this analysis (r = 0.318, n = 266, p = 0.000) revealed a moderate positive relationship between the two variables.

In contrast, belongingness experience with the organisation was indicated to be the highest significant relationship to job satisfaction for Hospital A respondents. The results of this analysis (r = 0.364, n = 266, p = 0.000) revealed a moderately positive relationship between the two variables. This might indicate that better opportunities, recognition, and support from the organisation helped the Hospital A respondents to feel greater satisfaction with their work. Table 5.12 shows the detail of respondents' belongingness experiences scores according to categories with their intrinsic feelings in the clinical workplace.

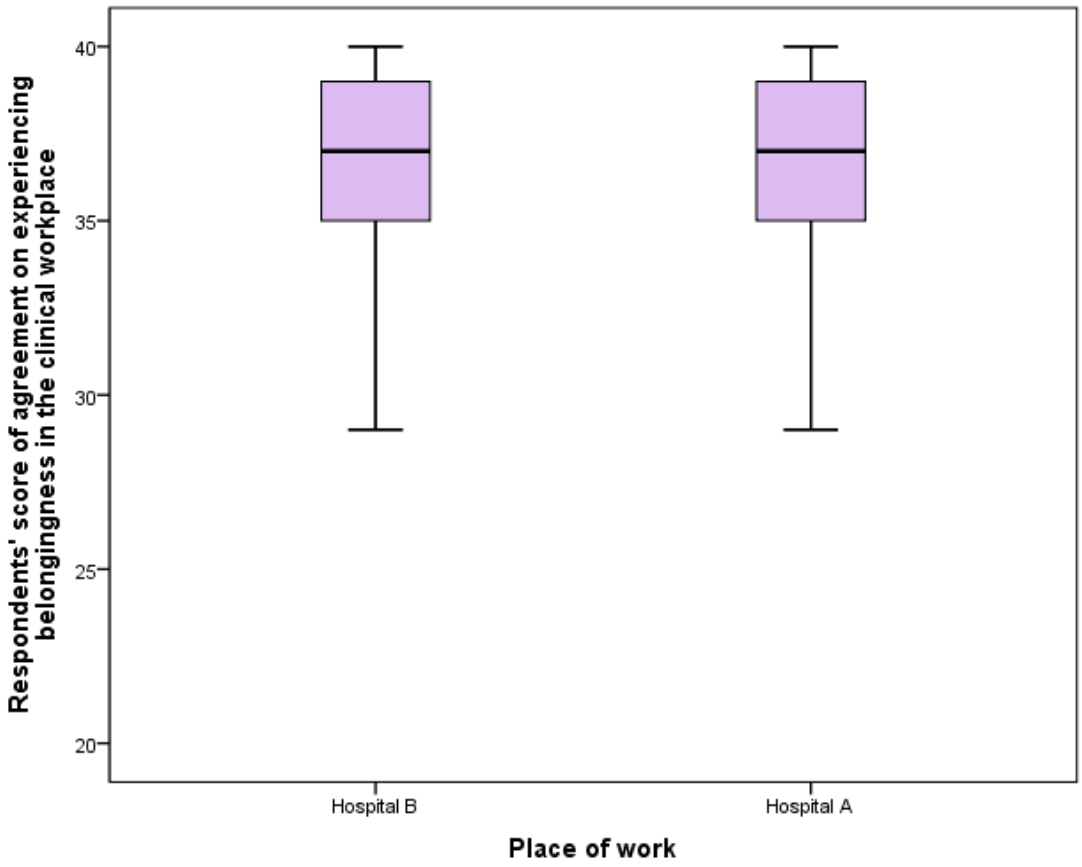
Table 5.12: Pearson Product-moment correlations between belongingness scores and perceived measures of motivation, confidence level and job satisfaction across hospitals.

Belongingness experiences	**Intrinsic motivation (*r*)**	**Confidence level (*r*)**	**Job satisfaction (*r*)**
Hospital A (*n* = 266)			
Colleagues	0.236	0.318	0.249
Other health care team members	0.311	0.318	0.214
Organisation	0.358	0.263	0.364
Hospital B (*n* = 169)			
Colleagues	0.181	0.360	0.387
Other health care team members	0.254	0.520	0.308
Organisation	0.246	0.530	0.415

r value effect (0.10 - 0.29 = small, 0.30 – 0.49 = medium, 0.50 – 1.0 = large).

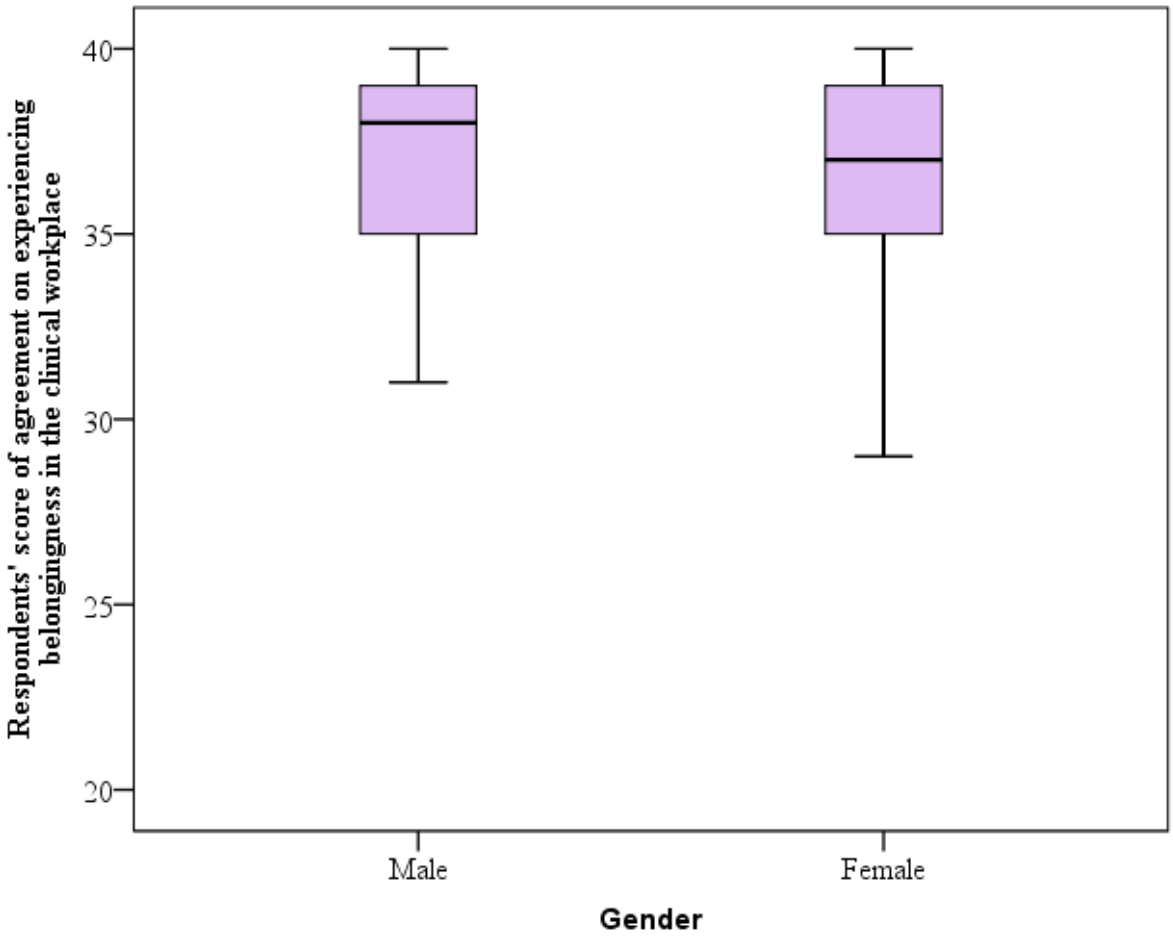
The researcher was then interested to explore whether there were any differences between scores of belongingness experiences with place of work and gender. An independent-samples t-test was conducted to compare the difference. There was no significant difference found in scores for place of work ($p > 0.05$). A parallel box plot between Hospital A and Hospital B shows an extremely similar distribution (Figure 5.6). This suggests that, on average, the sense of belonging experience was not found to be different between staff from the two hospitals; that is, Hospital A respondents did not have a higher sense of belonging than Hospital B respondents.

Figure 5.6: Place of work and belongingness experience in the clinical workplace (N = 435).



There was also no significant difference found in scores between gender and belongingness experience ($p > 0.05$). A parallel box plot between genders for both hospitals shows a quite similar distribution (Figure 5.7). This suggests that, on average, the sense of belonging experience was not found to be different between genders; that is, female respondents did not have a higher sense of belonging than male respondents.

Figure 5.7: Gender and belongingness experience in the clinical workplace (N = 435).



A one-way between-groups analysis of variance (ANOVA) was conducted to explore the difference between belongingness experience scores with age, years of experience since graduating from basic training, and years of experience in the individual's current clinical

area. There were no statistically significant differences at the $p > 0.05$ level in belongingness experience scores for age, years of nursing experience since graduation from basic nursing, and years of nursing experience in the current clinical area groups. A parallel box plot between age, years of experience since graduation, and years of experience in the current clinical area for both hospitals shows a quite similar distribution (Figures 5.8, 5.9, 5.10). This suggest that, on average, the sense of belonging experience was not found to be different between categorised groups in age, years of nursing experience since basic nursing, or years of nursing experience in the current clinical area for either hospital.

Figure 5.8: Age and belongingness experience in the clinical workplace (N = 435).

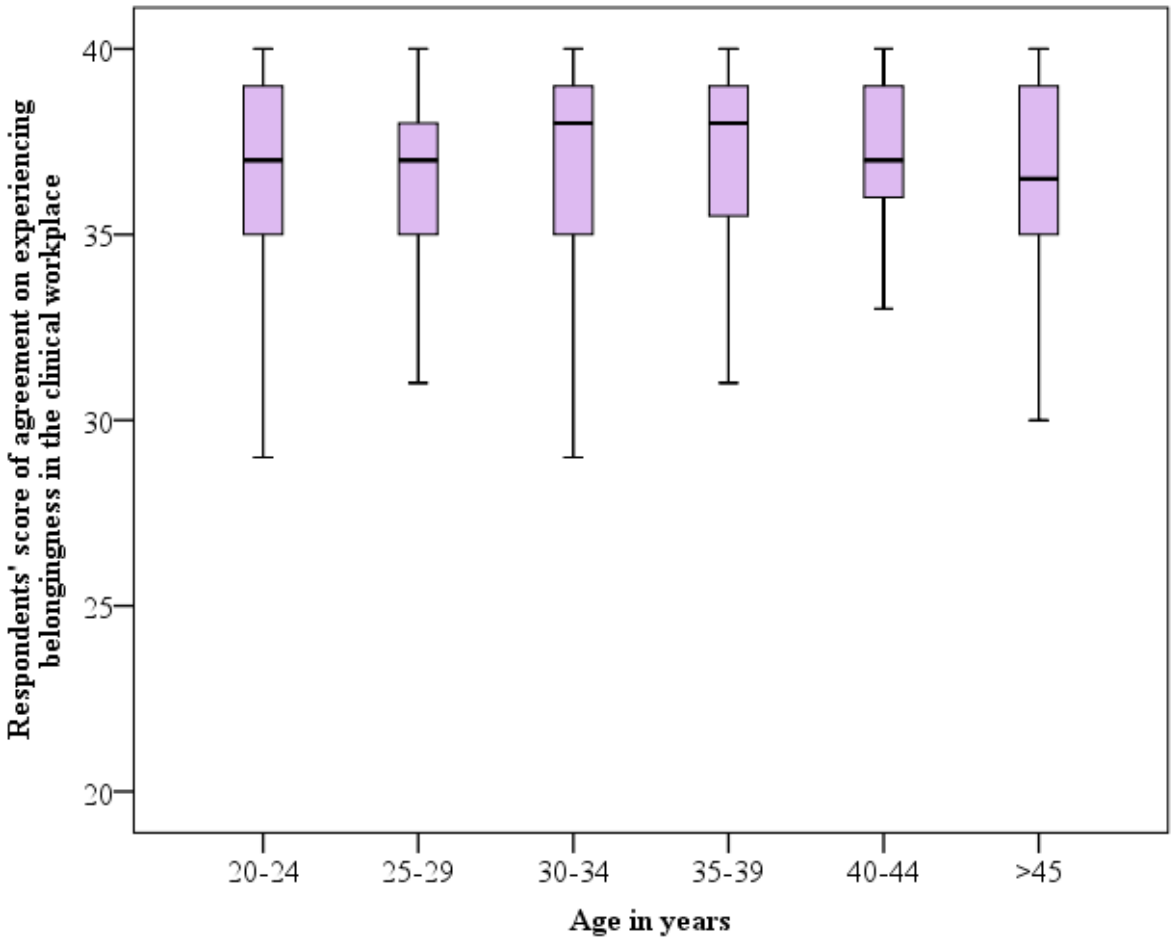


Figure 5.9: Years of experience since graduation from basic nursing and belongingness experience in the clinical workplace (N = 435).

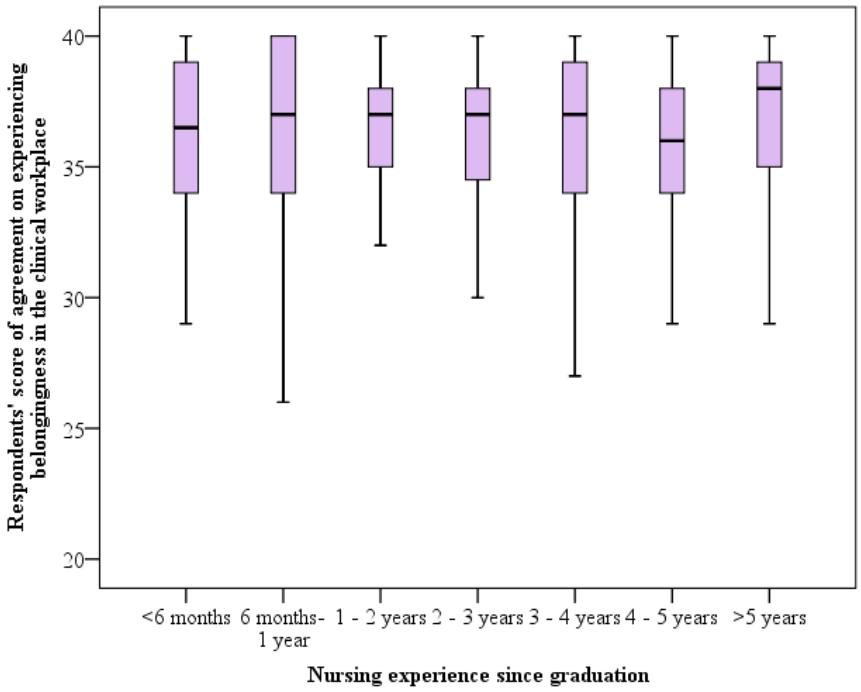
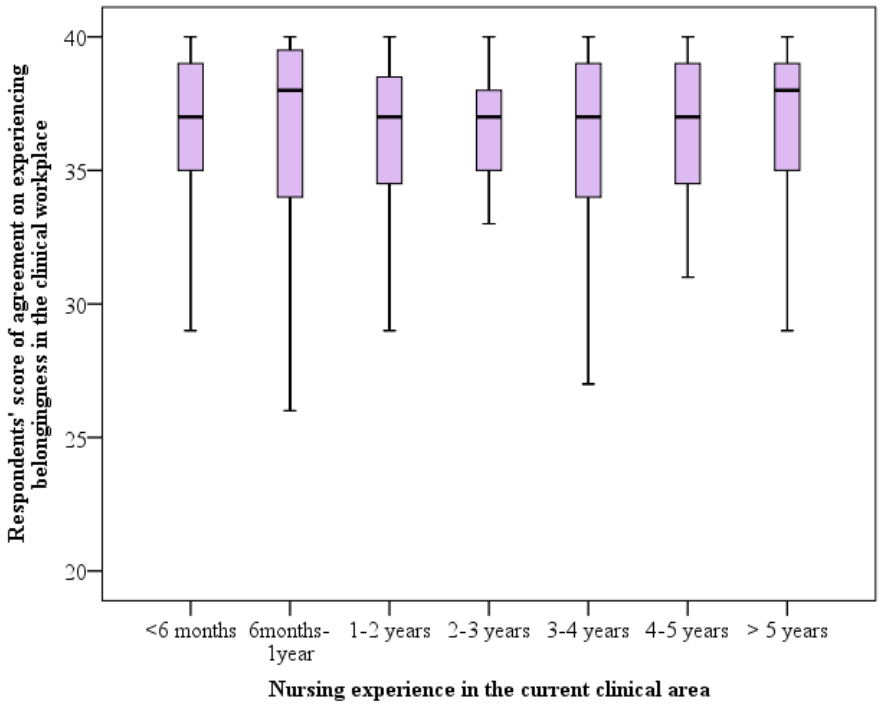


Figure 5.10: Years of experience in current clinical area and belongingness experience in the clinical workplace (*n* = 435).



5.7 Strategies to 'fit in' in the clinical workplace

The final part of the questionnaire asked respondents about their strategies for 'fitting in' in the clinical workplace, using an open-ended question. This analysis provides responses to research question number three: "What strategies do nurses currently use to fit in with colleagues and other health care team members?" Respondents were asked to outline the strategies they employed in order to fit in within their workplaces. Summative content analysis was used to analyse the strategies nurses reported using towards achieving or maintaining a sense of belonging in the workplace. Little is known about Malaysian nurses' attitudes towards this issue. Based on the researcher's reading of nursing literature and experience in nursing for more than twenty years, it was assumed that strategies employed by nurses with less work experiences would be different from the strategies employed by nurses with more work experience. Data analyses are reported under two main headings: i) strategies nurses used to fit in with colleagues, and ii) strategies nurses used to fit in with other health care team members.

5.7.1 Strategies to 'fit in' with colleagues

Seventy-five (17.2%) nurses who completed the survey chose not to answer this question on strategies to 'fit in' with colleagues. Of the 362 respondents who did answer the question, almost all of them were found to be using multiple strategies to fit in with their colleagues. A total of 18 different strategies were identified. Out of these 18 different strategies, "compromising with and tolerating colleagues to maintain a peaceful situation/ environment" seemed to be the most common strategy used by 209 (57.7%) nurses to fit in. "Practising teamwork in all tasks" was second with 201 (55.5%) stating they used this strategy. The third commonly used strategy "always respecting and being humble especially to senior colleagues" received 198 (54.7%) responses. These three frequently-used strategies imply that

the Malaysian nurses tried to maintain a peaceful working environment and harmony among colleagues with respect given to senior colleagues as their priority. Table 5.13 summarises the strategies nurses reported using to fit in with colleagues from the most frequent to the least reported.

Table 5.13: Strategies used to fit in with colleagues (*n* = 362).

No.	Strategy	*n*	%
1	Compromising with and tolerating colleagues to maintain a peaceful situation/ environment.	209	57.7
2	Practising teamwork in all tasks.	201	55.5
3	Always respecting and being humble especially to senior colleagues.	198	54.7
4	Always exchange ideas, opinions and suggestions regarding patient care or problems at work regardless of seniority.	139	38.4
5	Always willing to help colleagues in performing nursing care to their patients even if not requested.	125	34.5
6	Listen and accepting colleagues' opinions or suggestions where appropriate.	92	25.4
7	Always being cheerful, warm and friendly.	91	25.1
8	Always try to complete my assignments/ tasks before passing over to the next shift.	76	21.0
9	Being professional while on duty e.g. do not mix personal problems with work.	63	17.4
10	Understanding the personality type of colleagues prior to building relationships and communicate according to the personality type.	51	14.1
11	Interacting with good communication techniques to promote good relationships.	47	13.0
12	Sharing my knowledge and skills with colleagues and new staff.	46	12.7
13	Always think positive even under pressure.	27	7.5
14	Always follow instructions that have been given.	20	5.5
15	Respect colleagues' rights e.g. being punctual to work.	15	4.1
16	Voice my opinion depending on the type and mode of colleagues.	13	3.6
17	Constantly updating my knowledge and skills.	12	3.3
18	Appreciate colleagues' effort e.g. say thank you when they help.	8	2.2

5.7.2 Strategies to 'fit in' with other health care team members

From the analysis, ninety-nine (22.6%) nurses did not answer this question on strategies to 'fit in' with other health care team members. As for fitting in with colleagues, almost all nurses who answered this question were also found to be using multiple strategies to fit in with other health care team members. Respondents' strategies on how to fit in with other health care team members in the clinical workplace are shown in Table 5.14. There were a total of 14 different strategies. "Working together as a team" received the highest percentage (n = 240, 71%) of all the strategies. The second rank was "always follow the instructions that have been given" with 151 (44.7%) nurses stating use of this strategy. The third commonly used strategy, "respect them as team members and somebody with higher knowledge and experience" received 116 (34.3%) responses. These three frequently used strategies imply that Malaysian nurses tried to maintain a peaceful working environment with respect and obedience given to other health care team members as their priority. Content analyses were used to further understand the strategies to fit in and are presented in the next section.

Table 5.14: Strategies used to fit in with the other health care team members (*n* = 338)

No.	Strategy	*n*	%
1	Working together as a team.	240	71.0
2	Always follow the instructions that have been given.	151	44.7
3	Respect them as team members and somebody with higher knowledge and experience.	116	34.3
4	Always exchange ideas, opinions, and suggestions regarding patients' care.	94	27.8
5	Provide good quality of nursing care to gain respect and trust.	61	18.0
6	Being warm and friendly to build good rapport/relationship.	56	16.6
7	Always willing to help/assist the other health care team members.	51	15.1
8	Always ask about and re-confirm any uncertain or confusing patient's care plan provided to enhance my understanding and avoid problems.	32	9.5
9	Give my opinions or suggestions only if applicable or they ask for it.	27	8.0
10	Compromising with and tolerating each other to maintain good relationship.	20	6.0
11	Accepting guidance and suggestions and trying to correct the weakness.	19	5.6
12	Interacting with good communication techniques to promote good relationships.	17	5.0
13	Having an open-minded attitude.	8	2.4
14	Participate in activities organised by them.	5	1.5

5.7.3 Content analysis of strategies to fit in

Four categories emerged related to the respondents' strategies to fit in: *appropriate workplace behaviour, social influence, knowledge sharing, and personal strategy*.

Appropriate workplace behaviour

Appropriate workplace behaviour refers to nurses' awareness that they could function individually but needed each other to provide emotional and physical support in performing nursing care. It was considered important to practise appropriate workplace behaviour in order to avoid rejection and secure potential help and support at any time the nurses needed it. From the responses, *maintaining harmony* and *we're a team* emerged as their appropriate workplace behaviour strategies that enhanced their sense of belonging.

i) Maintaining harmony

Respondents in this study reported appreciating their teammates by cooperating with each other in performing their duties. The importance of cooperating, tolerating and compromising with each other was seen to contribute to maintenance of a peaceful situation/environment in the workplace. Compromising with each other was seen to be more vital with colleagues compared to the other health care team members where it was less frequently reported. Most of the respondents (n = 209, 57.7%) reported practising this type of action with colleagues:

> *Compromising with and tolerating colleagues to maintain a peaceful situation/ environment.*
>
> *Avoid being suspicious of colleagues.*

This suggests that respondents relied more on colleagues rather than the other health care team members in their workplace. The nurses placed a higher value on a harmonious

workplace rather than on personal satisfaction. Therefore, respondents readily compromised their own feelings for the sake of every colleague they were working with.

In maintaining harmony, respondents (n = 47, 13.0%) also reported that practising appropriate communication skills was important to help them promote good relationships with their colleagues. Appropriate communication skills were characterised as listening to colleagues when colleagues shared their feelings:

> *Interacting with good communication techniques to promote good relationship.*
>
> *Being a good listener when colleagues talk about their feelings.*

In practising appropriate communication techniques, thinking before saying something to prevent hurting a colleague's feelings was seen as crucial. Therefore, respondents (n = 51, 14.1%) stated they would learn about the personality type of colleagues prior to communicating with them:

> *Understanding the personality type of colleagues prior to building relationships and communicate according to the personality type.*
>
> *Behaving and interacting politely and courteously.*

ii) We're a team

'We're a team' characterised the importance nurses placed on working in a team. The majority of respondents believed that nursing was always about working together with colleagues (n = 201, 55.5%) and the other health care team members (n = 240, 71.0%). The teamwork statements were demonstrated in the following responses:

> *Practising teamwork in all tasks.*
>
> *Working together as a team.*

When respondents mentioned the importance of practising teamwork, they were aware that, in order to have team help offered to them any time they needed it, respondents needed to offer

themselves to help colleagues when those colleagues needed help in turn. Such a strategy was reported to have been practised by 125 (34.5%) respondents:

> *Always willing to help colleagues in delivering nursing care to their patients, even if not requested.*

The perception of the importance of working hand-in-hand also applied with the other health care team members. Fifty-one (15.1%) respondents believed that nursing needed to work together as one discipline within the health care organisation. Working together in a team was viewed as necessary, as each discipline in the organisation carried different roles and functions. Total patient care could only be achieved if all disciplines worked together towards patient care outcomes:

> *Always willing to help/assist the other health care team members.*

For participants, working in a nursing team was not always referred to as teamwork or helping each other. Even though a nurse only worked for eight hours over a shift, there was a recognition that they needed to think about their colleague who would be continuing their duty when they had finished. Finishing jobs that had been scheduled during the shift to avoid passing these over, was seen as one important strategy to fit in. This strategy was reported as being practised by 76 (21.0%) respondents, such as in the following examples:

> *Always try to complete my assignments/tasks before passing over to the next shift.*
>
> *Doing the tasks or assignments without delay.*

Social influence

Social influence reflects respondents' emotions, opinions, or behaviours that were affected by colleagues or workplace dominance. *Giving respect* and *being obedient* emerged from the responses as the important factors in gaining belongingness.

i) Giving respect

Giving respect reflects respondents' perceptions that working in a team required team members to respect each other. However, their *giving respect* was hierarchical, which meant the respect they offered was more when the others were more senior or in higher-ranking positions. As strategies to fit in with colleagues, being humble and respectful were reported as practised by over half the respondents (n = 198, 54.7%), significantly, to senior colleagues. It could not be established with certainty; however, whether the senior colleagues the respondents mentioned were considered senior due to age, work experiences, or both:

> *Always respect my colleagues, especially senior nurses.*
>
> *Always being humble, especially with senior colleagues.*

Similarly, many respondents (n = 116, 34.3%) stated that they respected the other health care team members as one of their team members. It cannot be established, however, if this respect for other health care team members referred to all other health care team members, or was only applicable to other health care team members with higher positions, for example medical officers and specialists. The following examples reflect this:

> *Respect them as team members and somebody with higher knowledge and experience.*
>
> *Try to understand their ways of thinking.*

Of those nurses who offered respect, some (n = 61, 18.0%) also strove to gain respect from health care team members by increasing their knowledge and efficiency in patient care:

> *Provide good quality nursing care to gain their respect.*
>
> *Updating my knowledge and skills to gain respect and trust.*
>
> *Being professional while on duty to gain respect.*
>
> *Show self-confidence.*

It seems that respect, either giving or accepting, was one important aspect of fitting in with the other health care team members. This suggests that the sense of belonging with the other health care team members would increase either by respecting or getting respect from them.

ii) Being obedient

The answer *following instructions* shows that some respondents perceived that obedience was one strategy for 'fitting in'. Respondents' strategies, however, were directed more towards when they received instructions from the other health care team members. Nearly half (n = 151, 44.7%) of respondents stated that they needed to follow the other health care team members' instructions compared to only (n = 20, 5.5%) with colleagues. This suggests that respondents in this study paid more attention, and really needed to be careful, if the instruction came from the other health care team members. Again, it could not be ascertained whether this only referred to instructions from somebody of higher rank, for example doctors and specialists, or instructions that came from any health care team member. The following examples stated:

> *Always follow instructions that have been given.*
>
> *Always be aware and follow ward rules and regulations.*
>
> *Do the job instructed quickly and thoroughly.*

This suggests that some respondents in this study perceived that they sometimes were subordinate when working with other health care team members.

Knowledge sharing

Knowledge sharing encompassed respondents' strategies to fit in by exchanging ideas and giving opinions and suggestions in discussions or meetings. One hundred and thirty-nine respondents (38.4%) mentioned they did this with colleagues:

Always exchange ideas, opinions and suggestions regarding patient care or problems at work regardless of seniority.

Always ask and seek advice of any unsure or confusing patient's care plan provided to avoid misunderstanding.

Similarly, respondents (n = 94, 27.8%) mentioned exchanging ideas and giving opinions and suggestions regarding patient care with other health care team members. The following statements illustrate this:

Always exchange ideas, opinions, and suggestions regarding patient's care.

Update them with the latest patient progress.

Carry out ward rounds with them.

Even though many respondents mentioned that they always exchanged ideas, opinions and suggestions regarding patient care with colleagues regardless of seniority, for some respondents, the case was somewhat different. A few respondents (n = 13, 3.6%) thought that, even though it was important to exchange opinions and suggestions with colleagues, they were more comfortable in exchanging knowledge whenever they were requested to or feeling comfortable about doing so:

Voice my opinion depending on type and mode of colleagues.

Provide comments only if necessary.

Similarly, in dealing with other health care team members, (n = 27, 8.0%) respondents stated they were more comfortable with exchanging knowledge when they were requested to or feeling comfortable about doing so:

Give my opinions or suggestions only if applicable.

Give my opinions or suggestions if *they ask for it.*

Even though only a few respondents reported this, these responses seem a little negative when answering such questions as strategies to be accepted. Again, it is difficult to ascertain if this

applied to all health care team members or whether it is hierarchical; that is, directed more to other health care team members in higher-ranking positions such as doctors and specialists.

While providing knowledge and sharing their expertise with colleagues, respondents (n = 92, 25.4%) mentioned they also needed to listen to colleagues' opinions and suggestions in an open-minded manner, and try to accept other colleagues' suggestions. The following examples explained:

> *Accepting criticism and suggestions from colleagues and trying to correct the weakness.*
>
> *Accepting colleagues' opinions and suggestions with an open mind.*
>
> *Being professional about colleagues' opinions.*

Some respondents (n = 19, 5.6%) recognised that they also needed to listen to the opinions and suggestions of other health professionals, be open-minded with their ideas, and try to accept their suggestions:

> *Accepting guidance and suggestions and trying to correct the weakness.*
>
> *Accepting their (the other health care team members) opinions and suggestions with an open mind.*
>
> *Being professional about their (the other health care team members') opinions.*

This suggests that respondents in this study practised two-way communication in sharing their opinions and suggestions in the clinical workplace.

Personal strategy

Personal strategy reflects the individuals' efforts to build good relationships. Some respondents (n = 91, 25.1%) saw the importance of being warm, honest and friendly with colleagues:

Always being cheerful, warm and friendly.

Introducing myself to new colleagues.

Practising non-discriminatory or non-judgmental attitudes to build good relationships.

Giving a smile and greeting colleagues when they arrive at the workplace.

Always say 'Hello' and ask 'How's life?'

Being honest and sincere towards colleagues, and everything I practised.

And similarly, fifty-six (16.6%) respondents stated the importance of being warm and friendly with other health care team members. The following statements illustrate this:

Always being cheerful, warm and friendly.

Introducing myself to them.

Giving a smile and greeting.

Always say 'hello' and ask 'how's life?'

Being honest and sincere towards other health care team members.

This suggests that respondents in this study were aware that acceptance and fitting in was perceived to be much easier through good relationships.

5.8 Summary

This chapter has presented quantitative findings from the survey regarding belongingness experience in the clinical workplace among Malaysian nurses in two different hospitals. This phase highlighted several significant findings of the belongingness experience in the clinical workplace and intrinsic motivation, feelings of confidence, and job satisfaction. There were significant associations found between belongingness experience and intrinsic motivation, confidence, and job satisfaction. The analysis found no significant relationship between age

and length of work experience since graduating, with the overall total score of belongingness experience in the clinical workplace. The analysis also found a slight difference in needs between respondents from the two hospitals. A high sense of belonging experience had the highest influence on Hospital B nurses' confidence levels, in contrast to intrinsic motivation and job satisfaction for Hospital A nurses. Teamwork, maintaining harmony, obedience, and respect dominated respondents' strategies to fit in. Chapter Five presents findings from the qualitative phase of the study.

Chapter Six: The Interviews

6.1 Introduction

The previous chapter provided broad information about belongingness perspectives from the survey. This chapter builds on this by presenting detailed perspectives on sense of belonging from interview participants in the current study. Using a phenomenological approach, based on the Van Manen's concept, participants' stories were examined to provide contextually rich and meaningful data pertaining to their experiences of belongingness in the workplace, thus enhancing understanding of their experiences. In these interviews, participants were asked what they understood about the concept of belongingness in the workplace and their experiences in performing their daily tasks involving multidisciplinary teams in the clinical workplace. Each participant openly and easily recalled diverse experiences, either observed, or personally encountered. This chapter begins with a brief description of each of the ten participants involved in this part of the study, and follows with the themes that emerged surrounding participants' experiences and perspectives of belongingness. The researcher chose all of the pseudonyms used in this study which have been used to protect the identities of participants.

6.2 The participants

Ten RSNs ranging in age from 22 to 56 years participated in individual, semi-structured interviews. All were of Malaysian nationality with different ethnicities. The nurses were working in either Hospital A (n = 7) or Hospital B (n = 3) with a varying range of nursing experiences. Two participants were newly graduated nurses with less than six months' experience in the nursing profession (participants one and two); six had between one and ten years' experience (participants three to eight), and the remaining two had more than ten years' nursing experience (participant nine and participant ten). Almost all participants had earned

diploma qualifications as their highest nursing qualification. In order to contextualise the participants' comments for the reader, a brief description of each person is outlined below:

Participant one: Aishah

Aishah was a 22-year-old newly graduated nurse from the Ministry of Higher Education nursing college, and of Malay descent. She was a Diploma holder who had only six months' nursing experience at the time of the interview. During her interview, Aishah seemed relatively closed with what was said and needed extra questioning to encourage her to clarify her point of view. She spoke in a soft voice. At the time of the interview, Aishah worked at Hospital B where she had begun to work on the Obstetrics and Gynaecology ward as her first placement.

Participant two: Nurul

Nurul, aged 37 years and of Malay ethnicity, had been working as a Nursing Aide for eleven years in several hospitals before furthering her studies in nursing. She had been recently awarded a Diploma in Nursing from the Ministry of Health Nursing College to work as a Registered Nurse. Nurul presented as very enthusiastic about her job as a Staff Nurse. She repeatedly mentioned her ambition to further her study in nursing. For the previous five months, Nurul had been working on the Orthopaedic Ward in Hospital A.

Participant three: Seri

Seri was of Malay ethnicity. At the time of the interview, she was 24 years of age. Seri had been working on an acute rehabilitation ward in Hospital A since graduating with her Diploma of Nursing the previous year. She presented as a confident young nurse, given the short duration of her nursing experience. She spoke with a loud, clear voice and was ready to

share her opinions. Seri had studied her basic nursing at a nursing college run by the Ministry of Health.

Participant four: Ahmad

Ahmad, a 22-year-old Malay male nurse, had worked for almost a year since graduating from the Ministry of Higher Education nursing college with his Diploma of Nursing. In his interview, he presented as an open-minded person, willing to share his opinions about nursing. At the time of the study, Ahmad worked on an Intensive Care Unit at Hospital B.

Participant five: Ali

Ali, a 25-year-old male nurse, was also of Malay descent and had been working at Hospital A for two years after graduating from the Ministry of Health Nursing College with his Diploma of Nursing. At the time of the interview, he was based on an acute surgical ward. Throughout his discussions, Ali seemed frustrated and exasperated with the nursing profession. He spoke with a low tone of voice when he talked about his negative experiences in nursing.

Participant six: Suzy

Suzy, a Diploma of Nursing holder, graduated from a private nursing college. She had been working for nearly three years on a Coronary Care Unit (CCU) in Hospital A. In her interview, Suzy seemed frustrated with the way people treated her as a nurse. She spoke with a low humble tone when she talked about her negative experiences in nursing. At the time of the interview she was 25 years old. Suzy's ethnicity was 'orang asli'.

Participant seven: Aliah

Since graduating three years previously from the Ministry of Health Nursing College with her Diploma of Nursing, Aliah had worked on an Ear, Nose and Throat (ENT) ward at Hospital A. She was a Malay nurse, aged 27 at the time of the interview. Aliah presented as an easy-going person. She seemed happy and satisfied with her workplace, and laughed a lot during the interview session.

Participant eight: Siti

Siti was a 28-year-old Malay nurse who held a Diploma of Nursing from the Ministry of Health Nursing College. She had been working for five years, although at the time of her interview, had only been based in Hospital A for the previous three years. Siti had changed workplaces twice within five years due to family commitments. She presented as an easygoing person and did not seem to have much trouble in her workplace. Siti smiled each time she finished her sentences. At the time of the interview, she was working in the Emergency and Outpatient Department.

Participant nine: Aminah

Aminah, a 42-year-old Malay nurse, had been working in various wards under the discipline of Obstetrics and Gynaecology at Hospital B. Having seventeen years of experience in nursing, her main roles had changed to monitoring ward situations, helping other nurses, doing orientation, teaching newcomers, and doing paperwork pertaining to nursing issues. In her interview, Aminah appeared as a very positive and confident nurse. She spoke in a clear, enthusiastic voice when giving her opinions and suggestions. Many times during the interview she shook her head when talking about an issue that she did not agree with. Out of

the ten participants, Aminah was the only one who had furthered her study to earn a degree qualification in nursing.

Participant ten: May

May, a 56-year-old Chinese woman, had been working at Hospital A on an acute medical ward. Due to her seniority, she was working office hours with her main roles being to monitor ward situations, help other nurses, provide orientation for newcomers, and complete paperwork pertaining to nursing. May had graduated thirty years previously with a Nursing Certificate from the nursing college run by the Ministry of Health. At her interview, May appeared to be a very confident nurse, who spoke in a loud voice. Her non-verbal communication presented as very excited with the topics being discussed; she constantly moved her hands and body as she spoke.

6.3 Emergent themes

From the data analysis, four themes emerged that related to the participants' sense of belonging. These were: *what it means to belong, being heard, finding a way to fit in, and the influence of Malay culture.*

6.3.1 What it means to belong

Interviews revealed that the meanings participants attributed to belongingness encompassed two central elements. These centred on being valued and accepted, and experiencing a positive workplace culture.

Being valued and accepted

'Being valued and accepted' was characterised by a sense that nurses felt they had been recognised in their clinical work. For some of them, this feeling helped in optimising their performance, or as acknowledgement that they had a contribution to make in their workplace. This is illustrated in the following quotes:

> Siti: *...when I feel like being valued and accepted, I will do the work with more sincerity.*
>
> Aminah: *... I should feel somebody acknowledged or listened to me when I gave my opinion… then only I can work together with the organisation...*

Ahmad further described how 'being valued and accepted' was so important to him to the extent that, if he did not feel valued and accepted, he was a bit hesitant to work with colleagues:

> Ahmad: *... it depends on how other people treat me. If they show that they need me and appreciate my work, I feel like I belong to the place and I will be happy to work with them.*

In particular, for some participants, the sense of being valued and accepted needed to be internalised – as illustrated by Suzy:

Suzy: *... having a sense that other people accept and respect me as a nurse… I must feel it in my heart… then only I know I belong.*

Similarly, Ali indicated how important it was that being accepted by others occurred on a continuous basis:

Ali: *...having a sense that I belong to somebody or something… having a sense of other people accepting me… it's a feeling that I can feel continuously in my heart… otherwise it will be up and down and bring no meaning…when everything is okay, the sense of belonging is strong, but when something triggers a situation, it will start again... We (nurses) need extra support during this peak hour…*

Being valued and accepted also created some tension and contradiction within the workplace. As a newcomer, Aishah contended that she needed to ask a lot of questions, as she was not familiar with her surroundings. She sometimes felt that some of her colleagues were annoyed by her asking too many questions and chose not to answer them. Feeling undervalued and not being accepted by colleagues made Aishah feel a bit sensitive and hesitant in approaching her colleagues to ask questions. This ignorance really influenced her emotions about coming to work:

Aishah: *... when colleagues ignore me, I feel scared… scared to ask… scared to work… it will make me feel stressed to come to work.*

Similarly, Ahmad also agreed that when he felt he was not being valued and accepted, he felt that his emotions were not stable and his work performance was jeopardised:

> Ahmad: *If I come to work and nobody wants to make friends with me, nobody wants to support me; I will feel sad and a bit depressed. When I am depressed, it will spontaneously decrease my work performance.*

When people undervalued the nursing profession, the situation made nurses feel disempowered, as nursing was not accepted as one of the multidisciplinary teams. Although an experienced nurse like May described taking charge of ward management, she nevertheless felt disappointed working with inconsistent support and understanding. In one example, her suggestion was rejected even though she may have had pertinent points in it, as illustrated by the following quote:

> May: *Patient request for first class ward (one bed per room), but patient's condition was not very stable. We might convince the doctor to keep the patient in open ward for better observation, but the patient kept complaining to the specialist saying nurses did not arrange for ward transfer… at the end, the specialist came and scolded nurses for not yet arranging and sending the patient to the first class ward even though you explained the situation. There is no use for us as a nurse to say anything.*

Participants from both hospitals stressed the importance of feeling 'valued and accepted'. They mentioned this as a significant contributor to their sense of belonging and it presented itself in different ways. Many of them described it as a positive accomplishment that brought happy and satisfactory moments into their nursing careers.

Happy and satisfying moments

'Happy and satisfying moments' reflects nurses' emotions when they felt they were part of the multidisciplinary team. Participants described how these moments of satisfaction directly affected their emotional feelings and their experiences of belongingness. To nurses in this study, a token of acknowledgement of this satisfying moment was just what they dreamed of in a workplace that involved so many disciplines and human characteristics. Situations that triggered these 'happy and satisfying moments' centred in experiences where their actions were acknowledged or they felt they had their opinions listened to. The following quote explains:

> Suzy: *... when a patient collapsed, I can feel a strong connection. At that time when I gave suggestions, the doctors and the specialists will listen… I felt really happy and satisfied with my work.*

And similarly:

> Ahmad: *... I noticed teamwork was very good during emergency (patient collapsed). Everybody knew their roles and worked together… doctors asked for nurses' opinions… nurses gave suggestions… everybody listened to each other…*

In describing the importance of being valued in belongingness experiences, Aminah commented that simply listening and explaining things met her needs for psychological support to work in her multidisciplinary clinical area. She felt supported rather than being left to struggle to understand the situations on her own:

Aminah: *...when I made mistakes, instead of scolding me, they explained to me. They gave examples and reasons to make me understand better… other times when I gave my opinion or suggestion, even though the management people didn't like my idea, at least they listened without interrupting me… then they discussed and told me why they could not agree with my opinion… so I felt more happy to work at my workplace.*

When nurses realised that their voices had been listened to, they felt accepted, appreciated, and more confident with their nursing activities. Ahmad explained:

Ahmad: *I feel happy, appreciated and more confident if somebody listened to my opinions or suggestions. At least I can see other people trust me and appreciate me… I think this is important because we work as a team.*

Interestingly, those positive feelings influenced them to share more ideas in the future:

Siti: *... when they listen to my opinion, I felt excited to voice out other opinions in future and feel happy to come to work.*

In addition to being valued and accepted as a way of generating a sense of belonging to the clinical workplace, some nurses were convinced that the workplace culture influenced their sense of belonging.

Workplace culture

'Workplace culture' was characterised by some nurses who actually did not have a passion to be nurses. The nurses' primary motivation to perform nursing duties actually came from the positive environment of their clinical workplace, which made them successfully grasp the true meaning of sense of belonging to the workplace. For these nurses, a placement in a clinical unit with a positive environment played a significant role to help them stay in nursing:

> Aliah: *We (colleagues and other team members) are very close to each other… I feel like we are one family… I had no interest in nursing since the very beginning… I stayed in nursing because I like the place where I work now… in future, I don't know yet.*

Similarly Seri, who was allocated to another clinical unit, found the same experience offered in her supportive clinical environments. Her feelings of belonging to the workplace helped her to perform nursing duties despite her expressed lack of interest in nursing:

> Seri: *I feel very encouraged… they (colleagues and other team members) listen to my opinion, they respect me as a nurse… if they think my opinion is not very suitable, they will discuss nicely and give me a reason why it cannot be accepted… we are very close to each other… I never had interest in nursing since the very beginning… I am not very sure I will stay in nursing if they (the management) shift me to other ward…*

Seri also shared her experience of being valued and supported which made her feel genuinely respected as a worker. The supportive team she had around her assured a comfortable workplace environment where she could ask questions, afford to have good teamwork and

practise most of her nursing skills. Seri pointed out how important she found it, when instead of doubting her capabilities; the people round her gave trust and assistance for her to perform nursing duties. The following quote illustrates this:

> Seri: *...during multidisciplinary meetings, the nurse in charge of the patient will present the case… request for family meeting if she think family support was poor, request for social welfare…give opinion on patient care… the doctors, the specialists, the sister, the senior nurses, the other team members… they always encourage me to talk and give opinion… doesn't matter if it is wrong…It is a bit difficult during the first few months because I feel scared, I am not confident… they didn't scold me but they continued to encourage me… I started to feel comfortable and I can do what I should do…*

The diversity of the participants' perspectives of a sense of belonging in the clinical workplace suggests that the notion of belongingness is not something fixed. It can be altered by the participants' experience, environments, culture or the situation experienced at the time. Consequently, while interest in nursing might influence nurses' performance, a strong sense of belonging experienced in their clinical workplace, helped nurses to build strong connections with the clinical environment. Because of the nature of the workplace, nurses are forced to confront various individuals each day as they work with patients, relatives, and the multidisciplinary teams. Therefore, it was important for the voices of this group of nurses to be heard in the clinical workplace.

6.3.2 'Being heard'

'Being heard' is a theme emerging through all stories and is characterised by the participants' experiences of struggling to show their true selves as nurses or struggling to perform nursing

duties. ‘Being heard’ was seen as the principal sign of being valued in the multi-disciplinary workplace, a sign often lacking. Aminah’s statement illustrate this:

> Aminah: *The management set a rule for example only husbands can come in, but if the patient knew someone in the management site, any other relatives can come in… and other patients started to complain. When we (nurses) argued with the management site they just don’t want to listen… they said they are the bosses.*

For some nurses, working with colleagues from other disciplines sometimes provoked feelings of frustration. As nursing care is linked with many disciplines, and nurses spend twenty-four hours a day with patients and in managing the ward, they seemed vulnerable to accumulating fault and blame for any errors that occurred. Ali shared his frustration about being blamed for something not totally his wrongdoing. Although he tried to explain, the situation became worse as the blame bounced back to him. Ali’s experience demonstrates how nurses can feel undervalued and lack control in their workplace:

> Ali: *Sometimes the fault was not totally ours, it was from other staff but we usually got the blame because we are there, we are the subordinates… every reason we gave was useless. It would bounce back to us. It looks like we cannot defend ourselves at all.*

Like Ali, Suzy experienced a situation where she was scolded for something that was not totally her wrongdoing. Unfortunately, the mistake was found during her time on duty. The disappointment swelled, when she got the blame and especially when she was shouted at in front of other people. She described feeling completely hopeless, confused and heartbroken, as illustrated by the following quote:

Suzy: *...sometimes they (doctors) just realised the mistakes unfortunately during the time I was in charge… when I try to defend myself, it will bounce back to me. It looks like the mistake was found during my time and I should take responsibility. No questions asked. If I really make a mistake, please tell me nicely… it's no good to shout and embarrass me in front of other people... I can accept if they tell me nicely… it makes me upset and hurts me a lot especially if the mistake was not totally from nursing and I am the one being scolded…*

The Nurse Manager or nurse in-charge often tried to provide support for nurses in harsh environments. For nurses, it seemed that the Nurse Manager or nurse in-charge was their saviour to liaise between them and other health care team members, although their attempts were not always successful:

Ali: *Thank goodness sometimes the nurse in-charge or the nurse manager who knows the situations will step out and try to explain… However, if they were not very confident with what they were saying, they will be scolded back by the medical specialist… Those (Nurse in-charge and Nurse Manager) usually then said they will investigate the mistake…*

Suzy agreed that Nurse Managers in her unit were all knowledgeable and had lots of experience in the workplace. It would seem, from Suzy's perspective, that attitudes, cultures and behaviours were difficult to overcome, and Nurse Managers were often powerless to influence the multidisciplinary workplace environments:

Suzy: *Our Nurse Manager had great knowledge and experience in nursing… but they still lose to the specialist when it comes to decision-making.*

Hoping for better recognition, some junior nurses thought that the nursing management in their organisations should not be dominated by senior nurses. To have different ways of thinking and strengthen the nursing community, nurses from different backgrounds should have opportunities to serve in the management area. For Ali, a balance of genders in nursing management was seen to possibly help in strengthening the nursing community:

Ali: *I hope one day there will be sister or matron from male nurses. So there will be a mix in nursing management, which helps to strengthen the nursing community.*

Like Ali, Ahmad also considered that a mixture of nurses with a range of ages in nursing management would add different ways of thinking:

Ahmad: *I think the new generation should be involved in nursing management. From there only can we get different ideas and maybe it could change some old fashioned way of thinking in the organisation and help ideas to grow. Otherwise it will be the same because almost all the people who had been promoted are the senior nurses. They have the same ideas of thinking or have to have the same ideas of thinking. How to hope for a change in nursing management?*

At nursing school, students were encouraged to speak out. They had learnt and had been given opportunities to participate in group discussions and make some arguments. However, in reality, what had been taught in nursing school was hardly practised on the ward. Aminah,

who contended that what she had learnt at school had vanished in the workplace routine and culture, raised the same issue.

> Aminah: *While I am in nursing school, I learnt communication skills. I had been taught how to talk, been encouraged to talk, participate in a group discussion. It doesn't matter if it was right or wrong. However, when we go to our clinical area, we dare not to talk as I fear somebody will scold us.*

It was evident that nurses struggled with the resistance displayed by some colleagues to other health care team members. Due to complicated situations, silence was sometimes chosen as the best way to avoid any undesirable circumstances, as evidenced in the following quotes:

> Nurul: *...nurses are related to each other. Sometimes misunderstandings happen… the more you explain the more complicated the situation becomes… that is why sometimes I just keep quiet rather than giving my opinion or explaining the real situations.*

Similarly, Ali also thought it was best to keep quiet if dealing with someone difficult, especially someone from the medical team whom he knew was fond of blaming nurses:

> Ali: *When I deal with the specialist who I knew liked to scold nurses, even though I knew the real situation, even though I had the answer, I dare not to speak…*

Apart from the struggle with other health care team members, nurses in this study also reported that they struggled within the nursing profession itself. Some nurses just could not help being disappointed with their own nursing community who created barriers to belonging.

Barriers to belonging

While being valued and accepted was very important, there were elements of professional behaviour that participants experienced that created a barrier to feeling a sense of belonging. 'Barriers to belonging' relates to participants who personally thought that some negative personality of the nursing personnel itself contributed to giving bad impressions to other health care members, patients, and relatives. Some nurses mentioned that, in hoping to be accepted and respected by others, showing professional behaviour was crucial:

> Nurul: *There are nurses who are not professional. They talk or laugh very loud; they shout to each other instead of going nearer to their colleagues… they give wrong information to patients and relatives. When colleagues, or doctors, or other health care team members, or even patients or relatives ask questions, some nurses will just answer 'I don't know'… these are all not professional acts…*

The following quote also describes another example of frustration with the nursing community, as experienced by Siti:

> Siti: *… Some nurses were so calculative, not thinking, and just rely on doctor's order… I think these types of nurses are the ones who shame the nursing profession…*

Similarly, performing nursing tasks with little respect would create more harm to the patient. Such things were seen as only hindering nursing from being valued and accepted:

> Ahmad: *Some nurses just like to do short cuts while doing nursing care… this is not good. It will jeopardise the patient's life… and how you would expect other people to respect us (nursing)…*

From May's perspective, respect for the nursing profession had gradually decreased since she first joined nursing. Some nurses, disappointingly, were seen as not doing their job intelligently when performing their daily nursing care for patients. May felt that, instead of just following the doctor's orders, nurses should use their knowledge to produce good nursing care outcomes. The following excerpt explains this:

> May: *A patient is on pain killers, but at the same time, the patient's pain score is already zero…If in a simple case like this nurses still cannot remind the doctor to stop the pain killer, then how? Last time the doctor always asked nurses' opinions, but now I can see it becomes less and less…*

The role of nursing leader was considered important because they were the managers of the ward. They remained key personnel in creating supportive and facilitative working environments, not only for nurses but also the other health care team members, the patients and their relatives. However, some participants had experienced negative behaviours by their managers or head of the ward and this impacted on their feelings, as the following quotes illustrate:

Ali: *Some nurses in charge or nurse managers did not defend nurses at all, but continue to blame us again…*

Aminah: *… if nurses make mistakes, the nursing management will scold the nurse like hell while actually the mistakes can be settled nicely.*

The importance of the nurse in-charge or the Nurse Manager in assisting and showing appreciation for their nursing staff was mentioned by a number of participants. By doing this, managers were also relaying the message that they, as the leaders, valued and supported their own nursing staff in all situations. From Ahmad's story, Nursing Managers or nurses-in-charge seemed to place more attention on other staff who had higher authority, rather than their own nursing staff:

Ahmad: *I think nursing management did not really appreciate their staff… sometimes they scold us for something that I think did not deserve to be scolded for… something that can be negotiable… you can scold your staff but, please at least give advice and teach your staff how to do it in a correct way. Please show some appreciation to your staff. If nurses won something, any award or something, please praise us on our initiative… don't ignore us… but if somebody from the top people, they will praise so absurdly.*

For Aminah, showing concern for staff welfare was another way to deliver a message that they, as manager, valued and appreciated their staff. Her story reflects how nursing management inadvertently overlooked this very basic need to aid a sense of belonging among nurses in the workplace:

Aminah: … *if their staff member is sick, management site should go and pay a visit, if a staff member suddenly needs to take an emergency leave because her child is sick, the next day when the staff member comes to work, just ask how is her child doing? …The staff member didn't want money, it is enough if her boss had a sense of concern about the staff member's welfare… however, when the staff member comes to work the next day, they will be scolded for taking emergency leave… shouting in front of other people and blaming the child for always being sick…*

Aminah also emphasised the importance of the nursing leader being able to control stress during peak hours at the clinical workplace. Aminah felt that peak hours could bring on a chaotic atmosphere and staff would start to feel stress from the workload that had accumulated. From Aminah's observations, everybody, starting from the top management, would start to place pressure on each other and the flow moves down to the subordinates, which are the nurses working in the ward. This situation will hinder a sense of belonging among nurses as they feel they are being ignored and undervalued. The following quote illustrates this:

Aminah: *…during peak hours, for example, overloading of patients… with the doctors, the staff, the ward supply… it's chaotic everywhere… everybody was tired. If the nursing leader remains calm, they can console their tired and stressed nurses by showing their appreciation and understanding. If the nurse in-charge is also stressed out, they start to scold their own nurses because she (nurse in-charge) has also got the pressure from the higher authority … At the end, it's the nurses who become the victims without anybody noticing it… This will make nurses so upset and feel unappreciated at all…*

When a sense of being valued and accepted is perceived as extremely difficult to procure in the workplace, something must be done to ensure it happens as expected. Therefore, nurses need to fight for their right to professional recognition, where they are being valued for their qualification. This is explored in the next section.

Recognition as a profession

'Recognition as a profession' reflected nurses' enthusiasm to improve nursing quality to enable them to be accepted and respected by colleagues and other health care team members in the clinical workplace. Updating knowledge was mentioned by a number of participants as an important element in influencing other people's recognition of the value of nursing:

> Nurul: *Nurses must always update their knowledge to progress in line with the other team members.*
>
> Siti: *Nurses should have an effort to update their knowledge. Please not be too obsessed with doctors.*
>
> Ahmad: *To me, if I know people already look down on me, I need to work up a bit to update my knowledge.*

For Aminah, nursing leaders were the most important nursing personnel with a need to update their knowledge, such as through undertaking degree studies, because the new knowledge would then influence their way of thinking:

> Aminah: *… to me, if you want to be a nursing leader, it is better for you to earn your degree first. You will have a different way of thinking and be enlightened by the way you think…*

Similarly, May also thought the most significant people who needed to update their knowledge were the nursing leaders as they were the first point of reference and the most responsible to teach their own nurses. From May's perspectives, if the nursing leaders had a lack of knowledge and experience, it might influence other people's perceptions towards nursing overall. The following excerpt illustrates this:

> May: *…to be a boss you really need to have a good knowledge… so it will be easy for your staff to ask questions and clarify something… nowadays you can be a sister [Nurse Unit Manager] at a very young age. Some of them have not even attended sub-specialty courses according to their specialised clinical area… so how? How do you give opinions to doctors or other people if you don't have knowledge?... instead of you teaching your staff, it's the staff telling you how to do things…How can others respect you as a nursing leader and respect nursing as a whole?*

While upgrading knowledge was mentioned by participants as one important element to gain acceptance and respect from colleagues and other health care team members, the perception of unfair treatment received by the nurses who had nursing degrees was disappointing, especially when nurses themselves argued about the professional status received by the nurses with degree qualification. The following quote illustrates:

> Siti: *We need to standardise our qualification. Let all nurses earn degrees in nursing… sometimes all senior nurses are diploma holders then suddenly came junior nurses who are degree holders but they have no work experience yet… some nurses*

especially the diploma holders said why should she (the newcomer with a degree) earn more payment…

What surprised Ahmad was the attitude shown by nurses themselves who seemed to be the ones who were not very happy with transformation of young inexperienced nurses from the diploma Grade U29 to the degree qualification Grade U41. Experience in nursing was a big issue debated among the senior nurses of whom the majority were still diploma holders. Most degree-holders, due to the perceived inequality they faced, migrated to other places that could offer them better salaries or recognition:

Ahmad: *…I am not sure why the U41 quota was so limited… some nurses with degrees got it while some others didn't got it…that is why most of them (nurses with degree qualifications) left to join private colleges or academic sites…and some more I don't understand, there is also objection from nurses itself to give Grade U41 to the degree holders…they (nurses with degree qualification) were disputed on their experience… they earn their degree… why must you envy them? What will you expect of their experience if they are new graduates?*

Aminah considered it was such a waste when nurses with degree qualifications left the clinical area due to unequal treatment that they received from the organisation as well as their nursing colleagues. Even though Aminah had earned a higher qualification than her own Nursing Manager, her passion for patient care made her stay to serve in the clinical area. However, she was not sure what her future decision would be:

Aminah: *I love nursing. I love my clinical practice. Even though I earnt my degree in nursing, I did not go and join nursing academia as I love to work with patients. It is such a waste if I leave my nursing practice. It is not easy to gain back all the experiences… but I am not sure in future.*

While the updating of knowledge was clearly perceived as important to nurses, maintaining clinical skills was another key element identified for gaining respect from colleagues and other health care team members. Ali observed that this was one important element, however, that was always neglected when nurses reached certain years of seniority. From Ali's perspective, a combination of knowledge, clinical practice and experience would produce a highly competent nurse, which would help not only in increasing individual confidence but also in gaining respect from colleagues and in providing recognition as a professional. He explained:

Ali: …*when a nurse becomes a senior, even though they are not promoted to a sister, senior nurses will go on divided duty. Many of them I see most of the time sit at the counter and do paperwork… when they stop practising their skill; they are actually good in theory but not practical wise. I think they should have initiative to make sure they continue their practical skills… then only we can say we are nurses with knowledge and experience… it helps to strengthen the nurses' foundation…it helps to increase confidence levels… even medical specialists still continue their practical skills and we can see how powerful their confidence level is…*

Aminah's statement on clinical practice further supports Ali's perspective of the role clinical practice plays in the recognition process. Aminah indicated that, due to her seniority, she

sometimes stopped practising her clinical skills to pay attention to ward management and paperwork. She agreed that when she stopped practising her clinical skills for a while, her confidence level dropped. Not only did she lose her confidence, but also her thoroughness in teaching students and other staff. Therefore, in order to avoid losing the skills and confidence, she needed to ensure she practised her clinical skills constantly rather than struggling to gain them back. The following quote illustrates this point:

> Aminah: *…as a midwife, if I do not practise my clinical skills for quite some time, I can feel my confidence level dropped… to start again is not easy. Therefore, to me clinical skills are important… I must do it on continuous basis… then only I can teach junior nurses, students, and others… then only I can easily pick up their mistakes while conducting deliveries if I myself am excellent in my clinical skills…*

From the participants' stories, it was evident that a positive experience of sense of belonging did play a role in influencing nurses' emotions in the workplace. The feeling of being valued and accepted did motivate nurses to feel happy to come back to work. In order to assure acceptance, nurses needed to find a way to fit in.

6.3.3 Finding a way to fit in

Because of the nature of the clinical workplace, nurses in this study realised that being accepted in the clinical workplace was important to them. The acceptance they received from their colleagues would ensure good teamwork during peak hours and this perspective is illustrated in the following quotes:

Siti: *...it is important because I am going to work with them. If I have good rapport, it will be easy to work together but if I have a bad relationship, it will not be very easy. Nursing always needs each other as we rely on teamwork. If we have good relationships, my colleagues will help if I am busy.*

Ahmad: *Our relationship with colleagues must be good... then good teamwork will occur… we need to help each other during peak hours.*

Nurul: *When they (colleagues) did not accept me, teamwork is a bit difficult…they (colleagues) will give many reasons not to help me when I need it.*

'Finding a way to fit in' reflects the strategies participants used and the experiences of what they went through in trying to find their place in the clinical workplace. In 'finding a way to fit in', two subthemes emerged that captured the different strategies that participants reported using. 'Following the flow' and 'winning hearts' emerged from the interviews with a number of participants in this study and are discussed next.

Following the flow

The data analysis revealed that choosing a strategy to fit into the workplace was dependent on the surrounding environment which included the workplace atmosphere, culture, personalities of ward staff, and character of the player wanting to fit in; for example, whether they were a newcomer, an intermediate, or nurse with more years of nursing experience. For newcomers, seeking information about ward routine and learning the personalities of staff were priorities. 'Following the flow' reflects nurses' actions in the clinical workplace where they did not question other staff members' instructions or suggestions. They just followed the flow in order to allow them to understand the culture and ways of working, as illustrated by Nurul:

Nurul: *I must know the personality of each person I work with… Let's say if this staff member says this thing is supposed to be done like this, I will follow, and suddenly when I work with another colleague, and she says something different from what I have been told before, I just follow what that staff member says first…. I will confirm later with other people.*

And similarly, Aishah suggested:

Aishah: *…I have to follow the flow because I am a newcomer… first I need to know their character… their personality…*

Aishah further contended that it was important for her to remember that she could not simply show her true self if she wanted to avoid stressful situations ahead. Without support from colleagues and other staff, it was impossible to avoid work tension, as nurses were seen to perform better with teamwork within the workplace. Aishah explained:

Aishah*: The start should be OK for the end to be good. I need to be patient and must have a good attitude… I always need to be careful on what I say or do to please other people, to make other people like me and accept me… If they see I am okay, not very calculative, not rebellious… I will be alright. When it is all right from the beginning, it will be easier at the end… Otherwise, it will be difficult for me if I need to manage something all on my own.*

It was not only newcomers with less than six months experience in the clinical workplace who mentioned following the flow of the ward culture, and establishing the personalities of

colleagues, but also other participants who had more years of experience in nursing, as the following quotes illustrate:

> Suzy: *I must follow their way, must show some respect and try to learn their way… otherwise they would reject me…*
>
> Aliah: *… everybody has their own style. So if I am working with this staff member, I will follow her style, if I am working with that staff member, I will follow her style.*

And similarly, May who had been nursing for thirty years, still thought going with the flow was one important aspect in a multidisciplinary clinical workplace, due to different human personalities:

> May: *There are different types of cliques at the workplace. So what you need to do is you need to adjust yourself according to which clique you are dealing with and go with the flow.*

Reflecting on her experience of being a newcomer each time she changed workplace, Siti, in addition to following the flow of the ward, also mentioned that being friendly to senior nurses was important. In terms of being friendly, she usually started the communication by asking questions before she did any procedure. Siti admitted that sometimes she asked something that she already knew to initiate good relationships with senior nurses in the ward:

> Siti: *I need to follow the flow and be friendly to the seniors… I cannot be so quiet. If I do not know, I have to ask… but even if I knew, I will ask too… by doing this, the*

senior nurses will feel that I always want to learn and not do something according to my own thoughts… when they see I listened to their opinions and guidance, it will be easy to start good relationships.

Similar to Siti, Nurul would also ask questions of her senior nurses just to promote acceptance, as is illustrated in the excerpt below:

Nurul: *…I always ask. It doesn't matter if I already know the news…it doesn't matter if I actually know how to do it…*

Some participants also mentioned winning the hearts of their colleagues as yet another strategy to fit in.

Winning their hearts

The expression 'winning their hearts' reflects actions taken by participants in order to be accepted by colleagues. A few participants mentioned helping colleagues during peak hours as one strategy to win their hearts and is illustrated in the following quote:

Aishah: *I really must know how to win their hearts… I will simply offer myself to help my colleagues once I am a bit free…*

Like Aishah, Siti also thought helping colleagues was one good way to 'win their hearts'. This action was the most remarkable, especially when she dealt with what she called the

‘difficult nurse’. Siti described the ‘difficult nurse’ as a nurse who was not easy to approach, and explained:

> Siti: *…I need to find a way… especially with seniors who were difficult to approach... I need to try to win their heart… one way is by helping them to complete their work. If she is in charge, she might be a little bit busy. If I have extra time, I will offer myself to help. Even when there is nothing to do, I will just offer to help and ask if I can be of assistance… gradually they will accept me.*

Though nurses were eager to find ways to fit in, in order to enhance their sense of belonging, tactics were nevertheless still bound to the culture where there were certain elements they needed to consider before making further actions.

6.3.4 The influence of Malaysian culture

‘The influence of Malaysian culture’ reflects participants’ personal upbringings and backgrounds. Participants considered that many actions were undertaken, not because they were nurses, but because they were raised and influenced in the Malaysian culture. In Malaysia, cultural aspect of respecting each other, especially elders and higher-ranking people, are still widely practised. The following quote illustrates how Aishah saw this as impacting on her workplace relationships:

> Aishah: *Malaysians are always bound to the culture of respecting older people…they are your senior… they are your boss… I as subordinate need to be timid a bit… if I can still keep it to myself, then I just keep quiet.*

Hierarchy is an integral part of Malaysian culture and the organisation of nursing work and the profession is well known in Malaysia for its hierarchical structure. This means that higher-ranking nurses are usually treated with more respect and obedience, adding another complicated layer by virtue of the hierarchy and culture. Aminah and Ahmad explained how this impacted them:

> Aminah: *…nursing likes to place emphasis on hierarchy. If she holds a great position, you as subordinate must treat her as an important person. If I have something to discuss, I must make an appointment…*
>
> Ahmad: *… if the big boss comes to our ward, we really need to show our respect to her…*

In spite of the cultural influence itself, from May's perspective, it was not easy to change the way people looked at it, as this type of practice had been in place for a long time:

> May: *…in nursing management, everything has to go through the proper channels… has to go step by step, level by level… this type of management has been practised for ages… whether you like it or not, you must respect their post as a boss.*

Apart from respect, nurses in this study also practised approaches of tolerating each other to maintain peace and harmony.

Maintaining harmony in the workplace

The virtue of 'maintaining harmony in the workplace' was characterised by nurses trying to tolerate the workplace surroundings to ensure that they would not create more harm than good. To Aliah, maintaining harmony was very important to ensure she would not work under pressure due to tense situations in the workplace.

> Aliah: *To me, if there are small things that I am not satisfied with in my ward, I will try not to be bothered and just keep quiet… It is not actually about whether we dare to comment or critique the person back, but we don't want to worsen the situation. It is not happy to work in an environment like that. It is better we set it aside and keep quiet to maintain the good environment.*

Aliah also shared her experience of having a difficult colleague in her ward. She mentioned that the particular nurse liked to blame other people if mistakes occurred, while at the same time she also made mistakes. Aliah stated that the sister of the ward was also aware of the situation; however, for the sake of maintaining harmony in the workplace, the sister in charge just ignored the situation. The situation was never resolved and problems continued to happen:

> Aliah: *… sister is also the same. Just let it be like that. Actually everybody realises the bad behaviour but nobody wants to take risk… ha…ha…ha… The problem continues just for the sake of maintaining the harmony of our workplace.*

Aminah had a slightly different opinion about the influence of the culture. Even though she agreed there were significant influences played by the culture itself in maintaining harmony in

the workplace, she also thought that the influence of culture indirectly hindered the sense of belonging among nurses. From Aminah's perspectives, the softness brought by the culture influenced Malaysian nurses to fail to be transparent with what was inside their hearts. They avoided expressing it, but rather, showed it through their reactions as illustrated in the following quote:

> Aminah: *I think our culture is the type that easily accepts something. We will just keep it in our hearts even if we are not satisfied… However, we can see it from their reactions… they always take emergency leave, sick leave… they don't want to follow orders… if we asked they will never say they are not satisfied… they will only show it from their reactions.*

Aminah further contended that staff who experienced a sense of belonging in the workplace would be easily managed and follow instructions, compared to those staff who had less sense of belonging:

> Aminah: *If the staff have a strong sense of belonging and feel satisfied with their working environment, they will easily follow instructions compared to the ones who are not satisfied. We need to reinforce them for so many times*.

Aminah further contended that Malaysian culture also influenced the ways Malaysian nurses communicated. She gave two examples on how the culture affected the communication process and thus indirectly influenced the sense of belonging.

Aminah: *Our culture also influences our way of communication… we don't have this kind of transparent talk. Once you said something that you are not satisfied with, till the end you will be in trouble. Another typical Malay culture is people are easily irritated and difficult to accept ideas or comments from someone junior in the workplace. To me, they actually want to voice out their opinion, let them voice it out. They might have something new that we never think about it… then it is up to you (as a leader or senior) whether to accept it or not. Therefore, for the ones who are kind of soft spoken, they will choose to keep quiet.*

Though some nurses dared to speak up, communication skill was crucial. Their ways of communicating should be regularly maintained to preserve harmony for all parties. Participants mentioned that communication skills were important due to the nature of their work. Maintaining harmony would also help in maintaining acceptance in the clinical workplace as illustrated in the following excerpt from Nurul:

Nurul: *When doing nursing, I need teamwork. Therefore, I need to think first before I talk. I cannot simply say you are wrong… you are supposed to do like this, like this, like this… It will only lead to misunderstanding and miscommunications.*

And similarly, Aminah expressed:

Aminah: *I must know how to use communication techniques, otherwise it will be a bit hard. We nurses are in the middle, so we have to know how to control situations.*

6.4 Summary of the chapter

The analysis of the interviews revealed that there were many factors influencing sense of belonging for nurses in this study. These included workplace culture, previous nursing experiences, and the Malaysian culture itself. Feelings of being valued and accepted were found to form the main core to promote sense of belonging among participants. When they sensed they had been valued and accepted, the participants described it as a happy and satisfying moment in the multidisciplinary workplace. For participants who did not have an interest in nursing, a positive workplace culture really promoted a sense of belonging and helped them stay and enjoy what they were doing as a nurse.

The sense of being undervalued and rejected by colleagues impacted on some participants' emotions at the workplace where they were frustrated and hesitant to go to work. Though there was a likelihood of being undervalued and rejected by nursing colleagues and other health care team members, participants chose to highlight barriers to belonging created by nurses themselves, such as negative professional behaviour and lack of support from nursing management. Difficulties and unfairness experienced by nurses with degree qualifications added a more bitter flavour to these complicated situations.

Finding a way for newcomers to fit in and maintaining acceptance were found to be most important for the participants. The strategies used to be accepted by their colleagues were not mainly influenced by their demographic characteristics, but rather by the workplace surroundings. All the strategies used to fit in were treated with caution by participants as they were still bound to the Malaysian culture, which demands certain aspects of good morale, politeness and respect for each other, especially for higher-ranking and senior colleagues.

6.5 Conclusion

The quandary of the feelings experienced by Malaysian nurses in the workplace where they wanted their voices to be heard without being scolded by people in higher authority will be discussed further in the next chapter. Even though Malaysian people uphold the Malay culture of respecting each other, being polite and caring for other peoples' feelings, the analysis revealed a mixture of attitudes and personalities in this study. These issues demand further attention for discussion as they impacted on the nurses' sense of belonging. The next chapter discusses the results in the context of existing international literature and are considered together with the findings from the quantitative survey.

Chapter Seven: Discussion

7.1 Introduction

Sense of belonging is one important component in influencing nurses' attitudes in the workplace. In this chapter, issues that lay behind the feeling of sense of belonging among Malaysian nurses will be discussed through interpreting both the quantitative and the qualitative data provided by participants through the survey and interviews. These factors, including belongingness experiences with colleagues, other health care team members and the organisation, will be considered in the broader context of available literature.

In regard to factors that influenced the development of nurses' intrinsic motivation, levels of confidence and job satisfaction will also be considered. The influencing factors that hindered the process of 'feeling I belong' were revealed more from the in-depth, one-to-one interviews when compared to the feedback collected from the survey design. There appeared to be some challenges experienced by nurses from both hospitals to the sense they belonged within the workplace. These challenges to belongingness were not only what they experienced with other health care team members or the organisation, but also what they experienced with their own nursing colleagues in the workplace. Strategies for acceptance and how to ensure belongingness does not remain an elusive concept will also be discussed. This chapter concludes with limitations of the study.

7.2 Respect and acceptance the way to belongingness

In relation to addressing the first research question, there was similarity found between nurses from the two hospitals. For belongingness experiences with colleagues and the other health care team members, the concept of belongingness was governed by the notion of acceptance. On the other hand, belongingness experiences with the organisation were experienced through

respecting people in authority. Ideas of acceptance and respect also appear to have governed the respondents' stories from their interviews. It appears that nurses in this study gained their sense of belonging through acceptance they received from surrounding people, and, through respect and obedience they gave to the people in authority. People in authority in this context means a person who had higher position, knowledge, or experience. Findings regarding the issue of respect were in contrast with those of Konrad et al. (1999), whose tools were used in the current study. Konrad et al. measured physicians' job satisfaction and motivation, finding their satisfaction came from the respect received from patients, families and general community. In nursing literature, instead of receiving respect, giving respect and being obedient in order to gain a sense of belonging was reported among nursing students, particularly to ward staff (Ousey, 2007; Sedgwick & Yonge, 2008). No existing literature that the researcher sourced reported that experienced nurses were also giving respect and being obedient to others, especially people in authority to enhance sense of belonging. This finding, however, parallels the values found in the Malaysian workforce as reported by Abdullah (1994).

Respondents stated that being accepted by colleagues and other health care team members not only heightened their sense of belonging, but also had power to influence their emotions within the workplace. Feeling happy, supported and more committed to work was reported when they felt they belonged, while feelings of sadness and fear were reported when they sensed they were rejected. Findings from previous studies have also highlighted that nurses felt energised to attend work, as a sense of belonging brought feelings of happiness, of being supported, and loved (Paton, 2010; Sedgwick & Rougeau, 2010); they reported stress, being scared and feeling alone with a lack of belongingness (Levett-Jones, 2007; Paton, 2010). Findings emerging from the current study support previous research in psychology and mental health, as discussed earlier, where lack of belongingness has been found to influence stress

levels and anxiety. The findings from the current study highlight that the implications of lack of belongingness are universal and can occur in any situation. In nursing, the current findings mirrored Levett-Jones et al.'s (2009a) study among nursing students in Australia where demographic characteristics were not strong influences of sense of belonging. It was the clinical environment and attitudes of staff that had greater influence. This could inform nursing management that providing supportive workplace environments is crucial for nurses.

Literature indicates that feelings of acceptance influence nurses' behaviour. As discussed earlier, previous studies have found that being accepted and respected as a colleague was more important than being accepted and respected by patients (Anderson & Edberg, 2010; Fink & Krugman, 2008). This finding is disconcerting, as a nurse who pays more attention to being accepted by colleagues could just follow his or her colleague's lead, never questioning any aspect of the workplace (DeMarco & Roberts, 2003). In line with DeMarco and Roberts' (2003) concerns, 'following the flow' of the ward routine and trying to 'win colleague's hearts' in order to become accepted emerged strongly from the qualitative findings of the current study. These actions have the potential to bring negative consequences for nursing care, with some respondents mentioning that they would follow the routine of the ward and not argue with colleagues' instructions and suggestions. This was highlighted by Nurul's practice where she indicated that, even if she thought something was wrong, she would not confront the senior nurses who provided her with that information. Nurul would just continue doing what she had been told previously and discuss it with other colleagues later, after she performed the nursing care. Participants practised this type of attitude to ensure they avoided exclusion by colleagues in the workplace.

Previous studies have found that 'following the flow' of the ward by becoming obedient, having respect for authority and seniority, and showing loyalty to the team were more

common among new graduates (Paton, 2010) and nursing students (Sedgwick & Yonge, 2008; Levett-Jones & Lathlean, 2009b). What makes the present findings different from these previous studies is that 'following the flow' and 'winning colleagues' hearts' were concepts practised not only by new graduates but also by senior nurses. Whilst this issue appears in the current study, it is important to note that many of the previous studies on nurses' belongingness have focused on the experiences of new graduates (Casey et al., 2004; Kovner et al., 2007) and nursing students (Ousey, 2007; Sedgwick & Yonge, 2008). The issue of senior nurses who still practise 'following the flow' and 'winning colleagues' hearts' has not been previously reported. This influence may be due to the Malay culture as enacted by the nurses in the workplace and will be further discussed in Section 7.2.1.

There were situations where respondents mentioned they sometimes felt accepted by being valued for their opinions and suggestions in certain situations; for example, in an emergency situation where the rescue team relied heavily on each other. However, the acceptance they received was not consistent. Nurses also tended to be undervalued again when something triggered another situation, thus the feeling of acceptance disappeared. Perhaps a supportive work environment is what is crucial here. Previous studies have highlighted the importance of creating supportive workplace environments for nurses; of reducing fear in newly graduated nurses (Zinsmeister & Schafer, 2009; Kovner, 2007), helping nursing students feel welcome, thus promoting learning (Levett-Jones, 2007; Ousey, 2007), and promoting job satisfaction and reducing turnover in graduate nurses (Paton, 2010).

Due to the nature of nurses' work patterns that are interdependent on each other, it is important to ensure that the supportive environment offered is on a continuous basis. The success in promoting continuous supportive workplace behaviour depends on the culture of the workplace shaped by nursing leaders (Bradbury-Jones et al., 2011, Malouf & West, 2011).

Positive cultural factors such as inclusion of staff, recognition of staff's contribution, and openly sharing information, or negative cultural factors such as bullying and a lack of feedback are significant in influencing team members' perception of how far the support system is available in their workplace (Henderson et al., 2013). Henderson et al. (2013) further emphasised that in terms of recognising the staff's contribution and rewarding their effort, the evaluation was not supposedly based on leader's observation only; all staff need to be involved and encouraged to recognise the value of each other and nominate staff for a reward. This type of practice is able to create a perception of positive support as this creates feelings of inclusion and acceptance received from team members (Henderson et al., 2013), and hence promote a sense of belonging among staff.

Valuing each other's contributions, teamwork, and appropriate communication skills has been proposed as a way to achieve belongingness (Germain & Cummings, 2010). Based on respondents' stories, however, it would appear that there may be difficulties in addressing Malaysian hospital staff and the surrounding community in achieving Germain and Cummings' (2010) suggestions. Participants mentioned that negative behaviour practised by some nurses further created barriers to them receiving full acceptance from people around them. When others see some nurses exhibiting such negative professional identities, they tend to look down on nurses as subordinate workers. If nurses are always being considered subordinate workers, it could hinder opportunities to reach the self-esteem level as proposed in Maslow's theory, and as discussed in Chapter Two. Subordinates are viewed by some as incapable of contributing to decision-making (Abraham, 1988, p. 62). Lim (2001) stated that ideas and suggestions presented by subordinates are often not valued by managers or people in higher authority in Malaysia, as they are only expected to implement policies obediently. In this study, participants reported being reminded that they were subordinate when they challenged their leaders regarding the violation of the policy set; being scolded when trying to

explain mistakes found during their time in charge; and being ignored when giving opinions or suggestions. These scenarios reflected Nolan's (1998) findings (as mentioned in Section 3.2.1) where nursing students reported they needed to follow the hospital way and dared not to challenge the staff, but do not appear to reflect nurses elsewhere. What might influence this situation in Malaysia is that nurses in this study were still diploma holders. In Malaysia, it is generally accepted that diploma nurses are "task oriented, obedient and passive, the result, perhaps, of low entry requirement and a teacher-centred, didactic approach in education" (Department of Higher Education, 2010, p. 25).

Previous studies on nurse-physician collaboration often lament the poor relationship between the professions, thus creating conflict and tension (Gershon et al., 2007; Yeh et al., 2010). In-depth interviews with nurses in this study, however, revealed that tensions did not entirely come from nurse and physician relationships alone; nursing management also contributed to the accumulated conflict. The relationships between nurses and nursing leaders were seen as predisposing factors that hindered the sense of belonging for nurses. Participants reported lack of appreciation, support, and encouragements from their own nursing leaders. In terms of colleagues, participants mentioned that acceptance was very important because nurses, by the nature of their work, rely on teamwork. If a nurse was rejected by colleagues, they would struggle in trying to finish their tasks in the workplace. This has previously be identified by Kalisch et al. (2010) where a high level of teamwork was reported as crucial in maintaining job satisfaction among nurses. Without support from colleagues, nurses may face many problems including lack of support and help, and become emotionally unstable due to stressful conditions (Orden et al. 2008). Therefore, belonging to a group can promote more effective functioning than can individual action.

It would seem that nurses in this study leaned towards acceptance, more than other issues, in order to secure a sense of belonging. Acceptance received from colleagues and other health care team members was seen to bring satisfaction and was interpreted as receiving respect and being acknowledged as a team member. Thus, acceptance was found to be a core factor in belongingness experiences with colleagues and other health care team members. In contrast, acceptance within the organisation was gained through respect that participants gave to people in authority. It would appear that people in authority, either from nursing or other departments, deserved respect from this group of participants. The situation of respecting 'superior people' might also suggest there was a direct influence of culture in this study. As discussed in Chapter One, in Malay culture, higher ranking or senior staff are well respected by their subordinates.

Apart from the nurses respecting administrative people, survey respondents agreed that they also received respect from the people in their organisation, as nurses were involved in making decisions. Participants felt they were well accepted in the organisation, as the organisation recognised nursing and, therefore, felt they strongly belonged to the organisation. However, a comparison of findings between survey responses and interviews showed that interviewees indicated they were ignored when giving suggestions. This appeared to happen between the interview participants and their team members. If nurses feel rejected in their own clinical area, then it is not unreasonable to assume that this rejection would transfer to their organisation. Yet, this did not emerge in the findings. Survey respondents indicated that they felt they belonged to the organisation and it is worth future studies to explore what may have been influencing such responses; the question is whether it is due to an underlying desire to be accepted by people in the organisation and 'to not rock the boat', or due to the underlying current that has emerged from this study in relation to understanding Malaysian nurses' belongingness experiences in the workplace – the Malay culture.

7.2.1 Cultural influences on belongingness in the workplace

As previously indicated, Malaysia is a multicultural country dominated by the Malay ethnicity. Respondents' demographics mirrored the general Malay population. Malaysia is dominated by Malay ethnicity, and although each ethnicity has its own culture and beliefs, the Malay culture is sometimes seen to also influence other ethnicities (Asma & Pedersen, 2003). The values of the culture that contribute part of the Malaysian people's identities are often carried into the workplace and influence the way people relate to one another in performing their daily work (Asma & Low, 2001). These values are likely to have some influence on their work behaviours and attitudes in the workplace (Asma & Low, 2001; Zohdi, 1999). The three major ethnic groups of Malaysia – Malays, Chinese and Indians – have been found to share similar work-related values (Abdullah, 1992; Hofstede, 1991). However, their work-related values have also been found to differ slightly, depending on the individual's ethnic upbringing, cultural identity, and religious beliefs (Lim, 2001; Sendut, Madsen, & Thong, 1990). Among these three ethnic groups, Malays have been found to have higher 'power distance', meaning, "the less powerful person in a society accepts inequality in power and considers it as normal"[1] (Lim, 2001, p. 211).

Such typical Malay values emerged in the interviews where participants were aware of their positions as subordinates in the nursing organisation. They shared that they would be mindful of always respecting their seniors and superiors and saw a need to be a little timid, by holding back any matters that they were not satisfied with and keeping them to themselves as long as they could. As previously discussed in Chapter One, Malay people are raised and expected to behave according to a rule of *budi*. It has been suggested that the value of *budi*, however,

[1] Normal in this context refers to a natural thing happening in daily life e.g. it is normal if those in authority do not listen to your opinion if you are the subordinate from a lower hierarchy in the society or workplace (Lim, 2001).

gears a workplace with a high 'power distance' culture to create a strong tendency for authoritative leadership styles (Rosner & Kleiner, 1998, p. 19). As Malay people are very loyal to leaders, the value of respect, however, would appear to override nurses' actions, thus complicating their achievement of sense of belonging in the workplace. The pervasiveness of Malay culture appeared to influence several dimensions of belongingness in terms of confidence, intrinsic motivation and job satisfaction. Therefore, reference to Malay culture is discussed accordingly throughout the next section.

7.3 Belongingness and intrinsic feelings

Pertaining to research question number two, belongingness did have a significant positive relationship with confidence levels, intrinsic motivation, and job satisfaction. This finding reflects previous studies where a sense of belonging has been found to increase motivation and confidence levels (Levett-Jones & Lathlean, 2008), and improve nurses' job satisfaction in the workplace (Paton, 2010). It is interesting that the relationship between belongingness and confidence levels was highly significant for nurses at Hospital B. This phenomenon could be influenced by certain factors associated with the demographics of nurses at Hospital B. The demographic characteristics illustrated that nurses from Hospital B were predominately in a younger age bracket and therefore their mean years of nursing experience were not as high as at Hospital A, even though the years of experience of respondents from Hospital B exceeded five years.

It appears from the survey data that years of experience had some influence on nurses' confidence levels and it has been demonstrated in previous research that years of working experience is a significant influencing variable on confidence level (Kramer, 1985; Nadzri, Galbreath, & Evans, 2011; Sims & Keenan, 1998). In the current study, though, Seri who had only one year of experience in nursing, felt she strongly belonged to her workplace. This was

attributed to positive and encouraging support she received from colleagues and other health care team members in her workplace. It was interesting to see how that high sense of belonging had transformed Seri into a confident nurse, despite her age and lack of interest in nursing.

Associated with lack of experience and confidence levels, May considered that junior nurses were timid in voicing their opinions or suggestions in the workplace. May's notion was supported by Lee, Heilmann and Near (2004) who found that senior workers were more confident about voicing their opinions or suggestions. A recent study by Nadzri et al. (2011) found that Malaysian workers, when they had reached a certain working level such as having many years of work experience, would somehow influence their behaviour in the workplace by making themselves more willing, with greater confidence in contributing information, suggestions and opinions. Thus, May's perspective on the importance of working experience would appear to be supported.

In considering developing confidence for junior nurses, there are two options available for nursing: i) by the traditional way, which lets junior nurses naturally collect their experience through their years of work, or ii) by providing support to the junior nurses, regardless of their years of work experience, as reflected in Seri's story. If nursing managers, or nurses themselves, think that the best way to gain confidence is by continuing the traditional way of working, which is to wait for a sufficient number of years to let confidence grow, it is concerning that nurses could be left too long lacking a sense of belonging. The consequence of a lack of sense of belonging, as discussed in Chapter Three, is clear. Nurses will leave or have the intention to leave the organisation which they think did not value them as a nurse (Levett-Jones et al., 2009a; Paton, 2010). While nursing school continues to educate more nursing students to produce more nursing graduates to fulfil government quotas, the nurse-to

patient-ratio continues to be distanced as nurses leave their positions for better recognition or better salaries (Hasselhorn, Tackenberg & Muller, 2003).

Even though Malaysian authorities have taken the initiative to increase nursing supply as mentioned in Chapter One, the greater numbers of new graduates and new international nurses entering the workforce have resulted in changes to the skill mix of many Malaysian hospitals. Clinical areas are now more likely to be staffed by younger nurses with less experience, placing strain on more experienced nurses to guide those junior nurses (Barnett et al., 2010). Because experienced nurses continue to leave the nursing profession, less experienced nurses are being left with less support and mentorship (Hill, 2010). The phenomenon will continue, if sense of belonging, which is at least part of the problem, continues to receive little attention from health administrators and nursing organisations.

Whilst Aminah agreed that experience in nursing did play a role in influencing nurses' confidence, she had a different perspective about seniority in the workplace. She perceived that the Malay culture could create irritation and difficulty for senior staff in accepting ideas or comments from someone junior, thus, detrimentally influencing the junior nurses' intrinsic feelings of being motivated, confident, and satisfied with their jobs. If the surrounding environment does not seem to support junior nurses, then it is unlikely that junior nurses will feel they belong within their workplace. With the strong influence of culture in the workplace, junior nurses might be perceived as just 'a pair of helping hands' by senior nurses, as reflected in Levett-Jones' (2007) and Bradbury-Jones et al.'s (2011) findings amongst nursing students on their clinical placements.

Aminah's way of thinking about seniority control in the nursing organisation may have been influenced by her undertaking a nursing degree. Sekera, Bagozzi and Charnigo (2009) found that education and training greatly improved leaders' ways of thinking, especially in complicated situations. Given that Aminah had more than ten years of experience in nursing when she undertook further study, her experience in nursing seemed to have influenced her behaviour, attitude, and ways of thinking. At the time of interview, Aminah was among the few Malaysian nurses with degree qualifications who remained motivated to stay working in the clinical area, even though she sometimes felt the pressure of being undervalued by people in higher authority.

Workers in Malaysia have been observed to work differently in their ways of thinking and daring to speak out (Asma & Pedersen, 2003). This is dependent on three factors. Firstly, the school stream; for example, the Chinese who graduate from government secondary schools, where the medium of instruction is the Malay language, reportedly behave differently from the Chinese who graduate from vernacular schools promoting a Mandarin stream (Norma, 2001). The former tend to be concerned about the impact of their behaviour on others and will only give their opinion on a specific issue after knowing what others have to say. They behave more like Malay people. Secondly, the place of study; for example, graduates from other countries such as the United States, Europe, or Australia tend to be more vocal in comparison to their local counterparts as the result of their exposure to Western culture. Thirdly, the level of education; for example, a certificate holder works differently from a degree holder in their way of thinking. From the way they respond in the workplace, it appears that workers with higher levels of education are more confident in articulating their ideas (Asma & Pedersen, 2003). Level of education was reflected in the interview where Aminah, as the only degree holder, had quite a different notion of nursing compared to the rest of the participants who were diploma holders.

7.3.1 Workplace motivators

Participation of staff in decision-making or knowledge-sharing does play a role in heightening confidence levels. Arnifa and Mohan (2011) suggest that participation of staff helps in reducing the concentration of power in the management site, as participation essentially means authority, decision responsibility, and information are shared across all levels of the organisation, as far as possible. This supports Tushman and O'Reilly's (2002) contention that employees must be encouraged to participate in exchanging information and sharing their knowledge in order to be a successful organisation. With respect to the experiences of this study's participants, Seri had clearly been given opportunities by her colleagues, nursing manager, and other health care team members to participate in decision-making and knowledge-sharing, which enhanced her confidence levels and sense of belonging compared to other respondents. Through such a supportive workplace environment, Seri was made to feel a valued member of the healthcare team, despite her apparent lack of interest in nursing.

However, not all nurses were fortunate enough to have such a supportive workplace. Several participants recalled situations where their roles as nurses had been ignored and they did not feel valued in the workplace. This is consistent with findings of previous nursing studies in terms of lack of support and encouragement. Levett-Jones and Lathlean (2008) and Bradbury-Jones, et al. (2011) reported that, while a number of students in their studies had positive placements, the support received was not optimised, thus negatively affecting their competence and confidence. The findings also mirror those of Nilsson, Hertting, Petterson, and Theorell (2005) who contend that confidence in the workplace is based on the existence of strong support from colleagues, managers, and other employees. Managers need to show their value and appreciation in action, rather than in words alone, in order to increase confidence among workers (Nilsson et al., 2005).

When nurses perceive themselves as empowered team members, they are motivated to perform, due to the additional purpose and meaning added to their work (Spence Laschinger, Wong, McMahon, & Kaufmann, 1999). Hence, they experience increased ability and confidence to perform their job well (Kramer, Maguire, & Brewer, 2007). Being valued as a person is quite simply about being treated with respect. A number of participants reported that they were scolded and shouted at in front of staff and patients, as in the examples shared by Ali and Suzy. Nurses being scolded and shouted at in front of other people by colleagues, nurse managers, doctors, and other health care staff is a universal problem in the nursing workforce. It is reflected elsewhere in the world and has been cited in the literature as workplace bullying or verbal abuse in the workplace. The bullying or abusing has reportedly involved nursing students (Mabuda, Potgieter & Alberts, 2009), and staff nurses regardless of seniority and gender (Kaminski & Sincox, 2012; Oweis & Diabat, 2005). This situation needs to be addressed, as, when all workers cooperate and respect each other, it helps in strengthening the levels of confidence (Nilsson et al., 2005), thus contributing to the sense of belonging.

It has been reported that nurses want to feel respected, to feel as if their colleagues listen to them and to show confidence in their professional abilities, thus implying that they are seen as competent and capable by others, including patients and relatives (Andersson & Edberg, 2010). This is important for nurses because they need to be involved in discussions with other disciplines regarding their patients' progress and not be a 'silent knower' just because they fear the power of the hierarchy in their healthcare organisations. In the current study, the majority of nurses surveyed felt they were treated with respect and were seen as competent. However, a dichotomy emerged in the findings from the interview participants. Nurses reported that, even though they knew the answers to questions or problems, they sometimes

chose to keep silent, especially when dealing with colleagues or other health care team members who tended to blame other people. Instead of nurses being a voice for the patient, they chose to be a 'silent knower' in the workplace. This occurred because they felt a lack of confidence in their ability to influence decisions and chose to remain silent even when this impacted on the quality of health care (Yeh et al., 2010). Thus, education level has the potential to play a role in boosting nurses' professional identities and sense of belonging in the workplace.

7.3.2 Educational influences

In this current study, motivation was also found to be related to sense of belonging in the workplace. Feeling motivated after graduating from nursing school, nurses might be enthusiastic when first arriving at their workplaces. Graduates emerge from nursing school with a coherent set of nursing ideals and values. In Malaysia, the nursing profession is still dominated by nurses with diplomas, from courses in which nurses were taught and introduced to the basic nursing skills within three-year programmes. In a desire to enhance nursing prestige, many nurses are furthering their education by earning nursing degrees. Johnson, Cowin, Wilson and Young (2012) suggest that education is essential to nurses' professional identities, as nurses become professional through education. However, the current study revealed that the acceptance received from other nursing colleagues in the workplace by experienced nurses with nursing degrees was different from the acceptance received by newly graduated nurses with nursing degrees (direct entry). In Malaysia, experienced nurses with degree qualifications were seen to be the most appropriate for promotion to higher-ranked nursing jobs, whereas in contrast, the newly graduated nurses (direct entry) were seen to be lacking nursing experience and practical skills, and therefore not yet suitable to hold any higher ranked nursing position. This reflects previous studies elsewhere regarding perceptions

that new graduate nurses are still considered not ready to practice in the clinical workplace (Hickey, 2009; Nelson, 2007).

In Malaysia, nurses with degree qualifications will earn a grade U41, which means they earn a higher salary than nurses with diploma qualification. Since this was introduced, experience in nursing was a big issue debated among the senior nurses of whom the majority were still diploma holders. This conflicting issue was not created by the organisation, but created more by the nursing community itself. Feeling discriminated against, newly graduated degree holders (direct entry) may leave their nursing professional roles in government hospitals and join other institutions. This finding was supported by Khomeiran, Yekta, Kiger, and Ahmadi (2006) who found that rejection by experienced nurses was among reasons cited by novice registered nurses in Iran for leaving the nursing profession.

In the current study, the workplace culture of respecting authority and seniority had hindered experienced nurses with degree qualifications from giving their opinions and suggestions in the workplace. Furthermore, community perceptions of nurses as subordinates in the clinical workplace were found to also create disappointment and further demotivate them to stay as nurses in the clinical area. As a result, this group of nurses also left their clinical work and joined other institutions. A lack of a sense of belonging will influence nurses' intentions to leave their work in the clinical area for any promising positions offered by other hospitals or foreign countries. This finding is in line with previous studies by Levett-Jones et al. (2009a) and Paton (2010) who found that future career decisions were influenced by belongingness, or the lack of it.

Almost all participants who took part in this study were of Malay ethnicity. According to Asma and Low (2001), for organisations with a majority of Malay employees, the reward

system should be geared towards group-based criteria, such as attractive fringe benefits that are strongly linked to pay and seniority or work experience. During interviews, participants revealed seniority and work experience issues to be further causes of demotivation in the workplace. In Malaysian nursing organisations, to see a junior nurse with degree qualifications work in nursing management or a junior nurse released to further his/her study is very rare. Offers of further study will usually go to senior nurses with at least five years of experience in nursing. The junior nurses in this study questioned why the nursing management needed to push senior nurses who were not motivated to further their studies, whilst the junior nurses were motivated to go. This waiting-in-queue situation appears to have hindered the sense of belonging among the junior nurses, as they felt undervalued by not having enough support and opportunities from the nursing management itself.

In the current study, several interview participants verbalised that they thought the younger generation should have opportunities to be included in nursing management. They felt that a better combination of genders and generations in Malaysia's nursing management was required to promote different ideas and ways of thinking. Thus, in the current workforce, there appears to be different modes of thinking between newer and more experienced nurses in Malaysia. This is not a new phenomenon in the nursing workforce, which is currently experiencing tensions between four generations of nurses (Newton et al., 2009). These generations are identified as the 'Traditionalists' or 'Silent Generation' (born pre 1946), 'Baby Boomers' (born 1946 – 1964), 'Generation X' (born 1965 – 1977), and 'Generation Y' (born post 1978) (Hart, 2006; Martin, 2004). Individuals in the same generational cohort are believed to share some common beliefs, values, and attitudes that are shaped by their life experiences (Lavoie-Tremblay, O'Brien-Pallas, Gelinas, Desforges, & Marchionni, 2008; Martin, 2004).

In the current study, attitudes of the 'Baby Boomer' generation nurses were shaped by their nursing experience; for example, following orders and respecting the seniority that they received their heritage from; that is, the 'Traditionalists' or 'Silent Generation'. This is in contrast to newly graduated nurses who mostly came from 'Generation Y". They expect constant feedback, praise, reward, opportunity, and appreciation for their contribution (Newton et al., 2009). However, when they enter the real nursing workplace, they confront contrasts to what they expected. This has the potential to create a sense of not being valued, and "only serves to highlight the need for clinical experiences that are invitational and can provide them with opportunities" (Newton et al., 2009, p. 633), rather than feeling satisfied and sincere towards their job. If these situations worsen, such a nursing culture will only provoke the novices to leave their employment as they receive lack of social support (Lavoie-Tremblay et al., 2008; Newton et al., 2009), which further impacts on their lack of sense of belonging. Despite interview participants' arguments regarding seniority, the survey results presented a different view, where 73% of respondents agreed that they received adequate opportunities for promotion and study leave from the organisation. Such high positive responses from the survey raises the question whether the 'Generation Y' and the 'Baby Boomer' nurses in the current study were really receiving adequate opportunities, or were instead both influenced by the earlier generation's traditional mind set, which was 'do not rock the boat'. This dichotomy finding needs further investigation as both of them have the ability to obscure the fact that nurses actually had been undervalued in terms of their true potential to perform in the clinical workplace.

7.3.3 Being undervalued

Organisational culture is considered a significant factor that influences both productivity and satisfaction among its members, especially when one undervalues the other (Gershon et al., 2007; Scott, Mannion, Marshall, & Davies, 2003). Tolerance of mistakes and celebration of

success are two important values in the organisational culture (Arnifa & Mohan, 2011). Participants in this study expressed frustrations in the ways nurses' mistakes or nurses' achievements were handled. They felt undervalued because colleagues were not listening to them, nurses were blamed no matter who had produced mistakes, and they were shouted at in front of other people because of mistakes. Being undervalued, as described by participants in the current study, was also the case many years ago and had been termed "hospital discipline" (The New York Times, 1909). The World Health Organisation (1999) reported that nursing staff are often the most at risk of being undervalued and experiencing verbal abuse. In this current study, the consequence of being undervalued, which has been masked under the term "hospital discipline", is that nurses felt they had a lack of control in their own workplace. This was further compounded by indifference from nursing management when respondents achieved success or were being awarded. Providing feedback and encouragement is an important element in promoting a sense of belonging among nurses as this has a strong positive impact on nurses' feelings of self-worth (Paton, 2010). However, this positive encouragement appeared to be lacking for this group of nurses.

Nurses in this study reported that, with the lack of continuous support and encouragement, they sometimes felt timid with others who had power in terms of authority or seniority. They felt inhibited by the traditional health organisation hierarchy which stressed power, and the Malay culture which stressed respect and maintenance of harmony, and they were self-conscious of the perception that nurses were seen as being subordinate workers. The signs and symptoms of dissatisfaction were seen in participants' body language and the way they spoke during interviews, particularly interviewees who had experienced being scolded and/or undervalued in the workplace. Continuous support, regardless of whether the staff member is making a mistake or bringing in a success story, will promote a sense of belonging. According to Brodtrick (1997), mistakes can be ignored, covered up, used to punish someone,

or perceived as learning opportunities. Arnifa and Mohan (2011) contend that a successful organisation should reward success and acknowledge failures or mistakes by creating opportunities to openly discuss and learn from mistakes. When managers actively work to create relationships that generate a caring and supportive work setting, job satisfaction increases (Paton, 2010), as mirrored in Seri's experience.

Systems within the health service have been identified as forming a convenient focus of blame when things go wrong (Francis, 2013; Williams & Walker, 2003). As health service members comprise a variety of different health care professionals, more diverse levels of explanation, beyond discipline-specific, may be required in order to make other team members understand an event, whereas members from the same clinical discipline may just accept points stated because they are more familiar with the environment (Williams & Walker, 2003). As mentioned in Chapter Three in Francis' (2013) report, anxiety or distress among staff nurses who worked in the Mid Staffordshire Hospital were due to fear of being scolded if they told the truth regarding poor management and leadership of the hospital. In the current study, however, feelings of anxiety or distress were due to fear of being scolded while performing daily work routines, and it seemed to affect the performance and the emotions of staff nurses. This would appear to be a unique finding within this study as such a finding does not seem to have emerged from any previous study on belongingness. It raises the question whether this scenario is a product of an underlying influence of the health organisation hierarchy and permeation of the Malay cultural values throughout the workplace environments.

As discussed in Chapter Two, previous studies on belongingness and social connectedness have revealed that people from the same group will unite to combat against any pressure or threat to their group (Anant, 1969; Baumeister & Leary, 1995). Nurses in this study, however,

reported incidents where their nursing leaders did not provide good support when they really needed it. Instead of investigating the problem and helping nurses to overcome problems, nursing leaders tended to blame nurses when they were pressured by their authorities. This 'oppressed group behaviour' eventually creates barriers against nurses feeling that they belong to the nursing profession. Nurses in this study agreed that their acceptance within the group was crucial. Several strategies were identified by the nurses to 'fit in' with their colleagues and other health care team members in the workplace.

7.4 'Fitting in'

It seems that for respondents in this study, 'fitting in' was an important element to continuously maintain throughout their careers as nurses, as it influenced their sense of belonging in the workplace. Whether they were new graduates or senior nurses, the strategies chosen were based more on yielding and maintaining group harmony. The notion of "*practising teamwork in all tasks*", *"cooperate with each other*", *"respect them as team members*" and *"always follow the instructions that have been given*" were given priority as their strategies to 'fit in' with colleagues and the other health care team members and reflects the literature from psychology and nursing as discussed in Chapter Two and Three. Caution should be advised for nurses in the current study, however, as individuals who try to meet their need to belong through cooperation cannot be guaranteed acceptance from others (De Cremer, 2003). However, when belongingness is successfully achieved, people become more willing to work in a collaborative and cooperative manner that reflects concern for others' wellbeing (De Cremer, 2006). In the current study, a cooperative and collaborative manner was seen as a survival technique for nurses to ensure they were accepted within the group and maintained what the nurses perceived as belonging to the group. Therefore, it cannot be ascertained that the nurses' cooperation truly emerged from the outcome of "I belong".

It also appears that nurses in the current study practised the value of collectivism – that is, teamwork, cooperation, a strong sense of belonging, priority to group interest, and satisfaction derived from respect from colleagues – as identified by Abdullah (1994) as one of the common cultural values among Malaysian workers. Practising the value of collectivism has been reflected elsewhere. Lee and Ko's (2010) study among Korean nurses found that it was necessary for nurses to cooperate with their nursing colleagues, the other team members they worked with, and the organisation they worked for, if they wanted to deliver better performance. This might be different in Western cultures. According to Triandis (1995) and Markus and Kitayama (1991), collectivism has been considered a fundamental principle in Eastern culture while individualism has been considered a core social value of Western culture. Individualism became apparent in Kelly's (1992) study among nursing students in America who believed that respect for others, which included colleagues, was basic to good nursing. Kelly's (1998) follow-up study on nursing students after one year following graduation found that the new graduates struggled with their vision of the kind of nurses they wanted to be, suffered a loss of their image of nursing as they believed it was, loss of the perception that they could make a difference in the clinical workplace, and loss of their dream of working collegially with colleagues in the clinical workplace as the reality of nursing work became evident.

It became apparent from the interviews that a majority of respondents chose to act as if they did not know many things, despite actually knowing the answer or the procedure. This reflects previous literature where such behaviour was termed as 'playing dumb' (Etheridge, 2007; Gove et al., 1980; Thornton et al., 2009; Yeh et al., 2010). 'Playing dumb' was a strategy utilised in seeking acceptance by listening to the advice of colleagues. What makes the findings from the current study related to collectivism is that, rather than showing they knew how to do something, they just showed others that they did not know many things. It is

important to remember at this point that the Malay culture is very conscious of respecting leaders and seniority. Respect for hierarchy, authority, seniors or the elderly is a typical aspect of Malaysian workers' identities (Abdullah, 1994). Therefore, by practising this type of behaviour, the workers were seen as not being 'show-off' types or trying to 'raise themselves up'. This was important to the nurses in this study as the acceptance they received from colleagues had the potential to influence their fates in the future, and ultimately their level of belongingness and job satisfaction. This is a bit different from Malouf and West's (2011) study among new graduates in Australia where the graduates did not want to appear 'stupid' to other staff members. The new graduates demonstrated that other people's perceptions of them were very important in determining their ability to be able to 'fit in' to the clinical environment. Therefore, they did not want other people to perceive them as 'stupid', even if they had a lack of knowledge (Malouf & West, 2011).

'Playing dumb' can also be influenced by the perceptions from nurses themselves that they are subordinates in the medical and nursing hierarchy. One reason identified by Gove et al. (1980) for workers who intended to 'play dumb' was that they perceived themselves as having lower job positions. Other than lower job position, 'playing dumb' was also popular among newly-graduated nurses (Gove et al., 1980). In this current study, 'playing dumb' was practised by new graduates or experienced nurses who had recently been moved to a new clinical area where they indicated that they just 'follow the flow'. A seminal study by Komarovsky (1946) among women college seniors in United States found that 'playing dumb' was not a good solution to a long-term event as it would lead to disappointment and stressful situations. This is in line with findings of the current study where respondents reported that they felt disappointed with the inequity they received from others; that is, their colleagues, other health care team members, and the organisation. Such a sense of inequity could impact on the promotion of sense of belonging among Malaysian nurses.

Respect for others, especially for people in authority, demands further explanation pertaining to the definition of belongingness itself. By the nature of the belongingness concept, nurses would be expected to report their personal experience of being valued, respected and accepted by colleagues, other health care team members and the organisation. However, it was the nurses themselves who stated that they must respect others in the workplace, and 'win colleagues' hearts' just to be assured that they were accepted by colleagues. It seems that the majority of nurses were bound to a perception of 'fitting in' behaviour. In this context, an individual will not argue, as their respect for authority and seniority requires them to act with deference, filial respect and obedience (Abdullah, 1994). Benson and Dundis (2003) contend that, in highly pressured environments that employees often find themselves working in, making others socially comfortable or 'fitting in' is given less and less consideration, which was in contrast with the findings of the current study.

Participants mentioned the importance of maintaining harmony and compromising with each other in the workplace as an important strategy as their work in nursing was based on teamwork. "*Compromise with colleagues to maintain harmony"* was among the top strategies participants used to fit in with colleagues. Even though there were issues that they were not satisfied with, either related to staff behaviour or ward management in the workplace, the participants reported trying to tolerate and compromise with it. Maintaining the balance of a calm and peaceful workplace environment was much more important than working in a stressful environment where friction might see changes for the better. By practising the 'do not rock the boat' code, participants could also avoid the consequences of being excluded from the group. This is in parallel with previous studies, as discussed in Chapter Two, that people who are able to maintain harmony avoid the consequences of group exclusion (Lakin, 2003; Lakin & Chartrand, 2005). This suggests that nurses in this study were the group that

was so desperate to be accepted, and they believed that group harmony had the ability to reduce further stressful workplace situations as reflected in previous literature (Baumeister & Leary, 1995; Janes & Olson, 2000; De Cremer, 2003). Therefore, nurses just put up with whatever feelings they had and keep these feelings to themselves. However, when nurses are so focused on maintaining harmony, playing safe, and conforming to others' views without objection, nurses will be seen as having weak identities and serving as subordinates. In addition, when nurses continued to be very careful when proposing their opinions or suggestions, and undermined issues that in their opinion would jeopardise group harmony, nurses were seen as not productive in a discussion, especially when the group discussion involved other health care team members and people in authority. Consequently, nurses might be excluded from discussion or decision-making if their contributions are not seen as productive.

Working in harmony by trying to compromise with others and by having non-confrontational behaviour has been linked with Malaysian people's identities (Abdullah, 1994). Malays pursue harmonious relationships through maintaining good moral behaviour guided by rules of correct behaviour and avoidance of actions that might disturb the traditional order (Lim, 2001). The Malay people's style of argument is "non-confrontational, non-competitive, gentle, friendly, and succumbing, as its final goal is consensus and compromise" (Lim, 2003, p. 31), and they look after other people's feelings (Goddard, 2000). Whilst collectivism values are synonymous with Eastern culture, Baumeister (1982) argued that, when anticipating on-going relationships, regardless of whether in Eastern or Western culture, it is common to see an individual adhering to social norms and expectations of the group. Baumeister (1982) further contended that this type of behaviour would be practised as individuals tended to dignify personal worth through work and the opinions of others rather than from within. Perhaps, in addition to the influence of Malay culture, the social norms existing in the current

study were also due to nurses' unsecured feelings of belongingness in the clinical workplace. This is an important point, as people will engage in this type of behaviour if their desire is to gain rewards, or as a means of becoming self-fulfilled (Baumeister, 1982), or for forming long-term stable associations built on genuine concern for each other (Baumeister & Leary, 1995). This point has important implications, as nurses struggle to achieve stable practice environments (Paton, 2010).

Whilst a strategy of maintaining harmony can bring a positive impact to certain situations, as mentioned by respondents in this study, it also can generate a negative outcome. As emphasised by Schermerhorn and Bond (1997), this type of value may just lead to undesirable consequences such as premature agreement and unquestioned obedience. Greenwood (1993) believed the nurses involved in this type of practice may become desensitised to human need and to poor nursing practice habits. Indeed, Levett-Jones (2007) found that one of her respondents with a Southeast Asian background found it difficult to say 'no' to the nursing staff she worked with. As a consequence, the student was blamed for a mistake that was not totally her wrongdoing. Being a student with a Southeast Asian background, she strongly carried the culture of respect and maintenance of harmony. Even though the nurse manager of the ward scolded her in front of other people, including the very nurses who encouraged her to commit the mistake, the student just took the blame without revealing the true story behind the incident (Levett-Jones, 2007). The concept of belongingness has been identified in this study as bringing many positive benefits for nurses. Issues expressed by participants in this study are realities that surround the nursing profession in Malaysia. With so many factors influencing the sense of belonging, it seems that promoting a sense of belonging is to promote an elusive concept.

7.5 Belongingness – from elusive to real

The nature and increasing complexity of nursing practice and the vast array of people who nurses interact with can create distress among nurses. Participants reported there were times they were ignored by patients, relatives, and other health care team members when they gave suggestions, or were scolded for mistakes that happened in the workplace. These negative experiences affected nurses' courage and sense of belongingness as they sensed that their nursing values were not in harmony with those of the group. Hence, the importance of support and moral courage from nursing leaders in enhancing nurses' dignity; leadership plays a role in ensuring belongingness is not just an elusive concept.

7.5.1 Nurse leader – responsibility, moral courage, and the sense of belonging

The need for humans to have a sense of connection with each other has been identified; however, the communities in which the human is connected had become increasingly fragmented and unsupportive (Wheatly, 2006). In the nursing community, the responsibility for creating a supportive work environment was thought to rest primarily with nurse leaders. However, it has been argued that many nurse leaders are not adequately prepared to focus on such challenges (Shirey, 2006; Sporrong, Arnetz, Hansson, Westerholm, & Hoglund, 2007; Weston, Falter, Lamb, & Mahon, 2008). Altun (2008) described how the current lack of empowered leaders in nursing practice is contributing to the dissatisfaction of nurses, and it has been identified that until nurse leaders can create appropriate nursing environments, existing settings will not change. This is an important point to consider as some nurses in this study expressed feelings of distress and frustration with their own current work setting. Nurses expressed their frustration and dissatisfaction towards nursing's leaders who were seen as unsupportive to their own nursing staff. Many studies, however, have reported that in spite of nurses' complaints of unsupportive nursing environments or of nursing leaders failing to create caring atmospheres within nursing practice, nurse leaders themselves struggled in

their attempts to create supportive environments (Donley, 2005; Bennett & Sawatzky, 2013; Kiekkas et al., 2008; Levett-Jones & Lathlean, 2007).

Moral courage has been suggested to be one effective way in building supportive nursing environments. Moral courage has been described as the individual ability and capacity to overcome fear and openly support one's core value either in public or private settings within healthcare organisations (Lachman, 2007). It is verbally acting to alleviate the initial moral distress felt by nurses in morally conflicted situations (Corley, 2002). The environment created by nurse leaders in the organisation is considered the most important aspect in promoting moral courage among nurses (Edmonson, 2010; Ketefian, 2001; Paton, 2010). When moral courage from nursing leaders is not encouraged, nurses feel demotivated and choose not to contribute their ideas in the workplace (Paton, 2010). This was reflected in the current study where participants mentioned that their voices were often silenced by the nature of the hierarchical practice within their organisations. In addition, nurses reported feeling frustrated that the knowledge of communication skills they acquired at nursing school was not readily transferred into the reality of clinical practice. As a result, participants reported that the nature of their clinical workplace often forced them to remain silent. As a nursing leader fostering moral courage, it is necessary to constantly urge nurses to continue voicing their opinions and suggestions, to reduce the negative consequences of the authority gradient (Edmonson, 2010). However, in the current study, the leaders' authority was seen to be inadvertently forcing them to keep silent, thus impeded nurses from feeling a sense of belonging in the workplace.

Clinician-organisation conflict is considered another important threat in promoting moral courage in nursing as nurses move between the clinical and administrative/ organisational domains in healthcare settings. Their decisions need to be multi-layered and contain

increasing elements of risk to themselves as nurses (Edmonson, 2010). In a typical situation where there is the influence of authority gradient and clinician-organisation conflict, support from the nursing leader to quickly allow for planning, discussion, and anticipation of outcomes may help nurses to overcome the frustrating situation (Wurzbach, 2008). Nurse leaders who intentionally provide for, and invite, open discussions of decisions have the greatest opportunity to assist their nurses manage a conflict situation (Edmonson, 2010; Henderson, Schoonbeek, et al., 2013). Henderson, Burmeister, et al. (2013) proposed that the immediate nursing leader, who is nurse in charge of the ward, is the best management person to provide immediate support because he or she works within the environment where his or her staff are working, and therefore understand the situations much better and are able to provide support needs according to their staff working context.

To promote a sense of belonging among nurses in the workplace, the nursing personnel, the other health care team members, the communities of practice, must all play their roles to create a continuous supportive environment for nurses. Providing support, opportunity, and open discussion can help to create a positive work atmosphere (Leftridge & Jordan, 2005), and thus increase nurses' levels of motivation, confidence and job satisfaction in the workplace. One of the major nursing responsibilities in a hospital organisation is providing quality nursing services to patients. As nurses care for patients as key frontline personnel, improvements in nursing performance are linked directly to the improvement of the hospital's organisational outcomes. The atmosphere of each nursing unit differs considerably depending on the disposition and leadership style and leader efficacy of the head nurse of the ward, as well as the learning atmosphere and culture in the ward, which was found to have an effect on nursing performance in one Korean medical institution (Lee & Ko, 2010). In the current study, Seri's story, versus other participants' stories, mirrored Lee and Ko's findings.

7.5.2 The influence of hierarchical power and leadership style

Hierarchical power in this study was not only influenced by the nature of nursing organisational leadership style, but also by the nature of the Malay culture. As discussed previously, Malay culture underpinned the workplace organisational culture within the current study. In spite of issues regarding hierarchical problems discussed in the interviews, the survey data on job satisfaction showed that 82.6% of the respondents agreed that they were satisfied with their current jobs. The survey findings, however, are in disaccord with Muzainah and Mahamad's (2010) findings in one organisation in Malaysia, in which hierarchical culture was the dominant culture of the department. They found that stress and job dissatisfaction was significantly correlated with the hierarchical culture (Muzainah & Mahamad, 2010). Thus, it is interesting that Malaysian nurses' opinions regarding their workplace environment appears to be a contradiction or that nurses in this study who indicated they were satisfied with their job were really obedient to the organisation or 'did not want to rock the boat' mind set.

When the organisation is so influenced by hierarchical power, it hinders the process of forming a transparent worker. Respecting the boss, and not acting against what they say, made subordinates reluctant to verbally share their dissatisfaction but rather, shows it through actions such as absenteeism and not following orders. Elovainio, Kivimaki and Vahtera (2002), who studied perceived organisational injustice among Finnish employees at one hospital found that employees who perceived low organisational justice demonstrated poor self-reporting and an increased level of absenteeism. Similarly, Kivimaki, Elovainio, Vahtera and Ferrie's (2003) study among hospital personnel in Finland found that more employees tended to take medical certificates to certify their absence when they perceived organisational injustice.

It is important to consider at this point that absenteeism could have a high impact on patient care and nurses' wellbeing, as nursing is known to be highly reliant on teamwork. Teamwork has been acknowledged as an important aspect of promoting sense of belonging (Cleary, Horsfall, Mannix, O'Hara-Aarons, & Jackson, 2011; McKenna & Newton, 2008). It is evident as, across the current study, those respondents repeatedly reinforced the value of teamwork in the nursing profession, as nurses, by nature of the work, will rely heavily on each other to perform patient care. Furthermore, if staff chose to exhibit their disappointment through bad behaviour, it would create negative assumptions about the nursing profession. Cohen-Charash and Byrne (2008) suggested that burnout due to organisational injustice has social and interpersonal implications for other staff as these symptoms are contagious and can affect colleagues. Rather than investigating the root source of the problem, one might presume that these workers are simply the type who likes to create problems. This will further create a barrier for other people to respect nursing, as the nursing profession is then seen to have problems with its own workers. As discussed previously, Maslow's theory contends that it is difficult to achieve the self-esteem level, which is respect and recognition from others, unless the belonging level has been achieved.

A leadership style that focuses on people and relationships in the workplace – for example, one that is transformational, resonant, supportive and showing consideration – has been associated with higher nurse job satisfaction (Cummings et al., 2010). Leaders who can display relational skills, concern for their employees as people, who can work collaboratively, and are concerned more with investing energy into relationships with nurses will positively affect the health and well-being of their nurses and improve patient outcomes (Cummings et al., 2010). In return, nurses may then reward their nurse leader through being engaged in their work (Germain & Cummings, 2010). This is evident in this study where, in one particular clinical unit, the nurse leader who reportedly practised a leadership style of informing,

encouraging and supporting staff, regardless of making mistakes or successful achievement, received the outcomes of a positive workplace culture as reflected by Seri. As evidenced in previous literature, effective nursing leadership is essential to the creation of workplace environments that support nurses' abilities to perform (Germain & Cummings, 2010; Henderson, Burmeister, et al., 2013; Henderson, Schoonbeek, et al., 2013; Newton et al., 2009; Paton, 2010), and it seems from the findings of this current study, to create a sense of belonging.

7.6 Limitations of the study

Though the sample size for the survey was large (n = 437) and the effect size was sufficient to represent the population of the two hospitals in the current study, the overall response rate was only 13.2%. There could have been a difference between respondents' and non-respondents' perceptions of the belongingness experience in the clinical workplace. Furthermore, the overall response rate from male nurses was only 1% and thus it could not be determined if there was a difference in responses between genders. Unavoidably, the time of data collection fell in the middle of the Muslim fasting month, which was too near to the Eid celebration. The lower than anticipated response might also be due to the existence of nurses with negative experiences who, due to culture or fear of 'rocking the boat', did not want to reveal this. It is possible that the 13.2% is largely skewed to nurses with reasonably stable and happy work experiences. Therefore, the survey data may be positively skewed as the majority, agreed and strongly agreed with each statement in the questionnaire. However, this study also had outliers. Nine scores were considered as outliers with two of them being extreme points. The two extreme outliers were removed from the survey data and their responses may have reflected a non-compliant mind set to the general Malay culture.

Data were collected in only two different hospitals located in Kuala Lumpur, the capital city of Malaysia; therefore, this limits the generalisability of the results to those hospitals. It is possible there could be a difference with nurses at other hospitals and other areas of Malaysia. However, drawing on a search of the literature on nurses' workplaces, the history of nursing over many decades, and on Malay culture, it may be that the descriptions of belongingness experiences in this study make them recognisable in other hospitals in Malaysia. Under the pervasiveness of the culture, even though Malaysia is a multicultural country, the majority of the participants were Malays. This gave an advantage for the Malay culture to influence the findings of this study, and limiting understanding of the belongingness concept in nursing upon other ethnicities in the workplace. Despite the dominance of Malay culture, this study relied on the use of an imposed approach; that is, the use of two Western-developed instruments on an Eastern society.

Interview participants may have been drawn to participating as a means of voicing issues. Those who were satisfied within their workplace might have been less inclined to volunteer. Evaluating the level of candour from participants during the interviews, as there is no way to verify such information, was another limitation of this study. However, it is hoped that by providing privacy, and building trust and rapport prior to the interview session, has helped participants feel more relaxed and willing to share their experiences with the interviewer. Even though it was not easy to gather information from some participants – due to them being cautious of what they said – the answers they gave were rich in content and reflected Malaysian nurses' real lives in the clinical setting. Lastly, the relationships between belongingness scores and feelings of confidence were significantly higher for Hospital B. Even though the age bracket of nurses for Hospital B was dominated by younger nurses, the researcher cannot be certain what exactly influenced this finding. Whether this was influenced by the nurses' demographic characteristics themselves or by the workplace environment could

not be determined. Thus, factors influencing nurses' sense of belonging and confidence levels in Hospital B remain unclear.

7.7 Summary of chapter

The nurses in this study predominantly gained their sense of belonging through acceptance they received from colleagues and other health care team members, and also through respect they gave to people in the hospital. This study has shown how the belongingness concept is important in promoting nurses' attitudes. This chapter has presented assertions from the results of this study and argued that changes both within workplace culture and nursing personnel are important, as the present situation creates barriers to a sense of belonging among the nurses. It has also highlighted where these findings are positioned within the larger context. The implication of this lack of a sense of belonging and influence of Malay culture were also discussed. More importantly, the tension between these two issues impacts on the development of a sense of belonging and influences the attitudes of Malaysian nurses. In the next chapter of this study, I return to the research aim, the value this current study adds, and offer my concluding thoughts on the sense of belonging among Malaysian graduate nurses.

Chapter Eight: Conceptual Framework and Conclusion

8.1 Introduction

An understanding of the belongingness concept from the nurses' perspectives is necessary in order to find common meanings and is vital for all the parties who deal with nurses; as well, it helps to gain insight into the meaning of what nurses value in their everyday belongingness experiences in the workplace. A survey was used to explore how nurses valued belonging, the relationship between belongingness experiences with motivation, confidence and job satisfaction, and strategies nurses used to 'fit in' with colleagues and other health care team members in the workplace. The interviews focused on capturing participants' personal experiences rather than developing an abstract theory on belongingness experiences among Malaysian nurses in the workplace. As researcher, I was interested to find similarities with, and also differences from, the current literature related to belongingness experiences that had emanated from a western context. This chapter draws together what has been learnt from this mixed-methods study with regard to nurses' perceptions of their belongingness experiences by revisiting the research questions, and makes recommendations for future directions.

8.2 The research questions

The first research question was concerned with interpreting the values of belongingness that nurses experienced in the clinical workplace. Belongingness experiences were rated favourably by nurses. However, even though a majority of respondents rated favourably, there were several outliers where respondents declared that they did not have pleasant belongingness experiences in the workplace. These were contextualised within the interviews when respondents were encouraged to talk about their experiences and were open in expressing their opinions. It can be concluded that nurses in this study were adopting a careful attitude in expressing their opinions in print, thus, giving mixed messages for the findings.

The data from this research question has served to generate further questions for subsequent research. It has left me questioning the significance of 1) using a Western-developed questionnaire in the Eastern setting where cultural values and collectivism influences are strong, and 2) if an Eastern-based questionnaire on belongingness experiences was developed in future, what level of openness could be expected from the respondents through the questionnaire. This appears to have a direct impact on understanding Malaysian nurses' experiences in the workplace.

The second research question sought to address whether relationships existed between nurses' belongingness experiences and their intrinsic feelings relating to motivation levels, confidence levels and job satisfaction. The results highlight that there were significant relationships between the variables. The more the nurses felt they belonged within the organisation, the higher their intrinsic feelings were. However, in this study, a sense of belonging was highly significant in influencing nurses' confidence levels for those working at Hospital B, compared to Hospital A, where the three variables had more or less equal significance. It is suggested that a supportive nursing environment is crucial in promoting sense of belonging among nurses in the workplace.

In seeking to answer the third research question about what strategies nurses used to fit in with colleagues and other health care team members, it was found that respect, obedience, compromising, and tolerating each other were popular among participants in this current study. This may indicate the influence of Malay culture in the workplace setting where higher ranking or senior staff are highly respected by their subordinates. The influence of Malay culture where Malaysian people were bound to the rule of *budi* could have overridden the nurses' actions to belong. It also appeared to influence nurses' experiences where the concept concerned the notion of respect for people in authority and compromising with colleagues in

order to be accepted by defined people. Acceptance was found to be one important factor in influencing a sense of belonging for this group of nurses.

8.3 Implications of the study

Sense of belonging has been explored with nurses and nursing students where, in many Western contexts as well, nurses have been found to lack a sense of belonging due to hierarchical power. The belongingness experiences of nurses in Western countries might not be the same as those of nurses in Eastern countries, particularly in Malaysia. In Malaysia, respect for hierarchical power and seniority is the common practice. This traditional culture has permeated into many workplace environments including nursing. Given that there was an influence of Malay culture in the workplace, it cannot be expected that change will happen overnight. Culture changes slowly, yet adequate data, appropriate tools, and strong leadership can facilitate this change. Fluctuations in staffing, complexity and reliance on multiple departments to accomplish work have created a chaotic practice environment. It is best to understand that positive changes in hospital settings and workplace culture would offer positive advantages not only for nurses and the organisations, but also for patients' safety and satisfaction.

Even though the survey found highly positive belongingness experiences, the stories from the interviews contradicted this finding, suggesting that the reality of belongingness experiences among Malaysian nurses creates dissonance. To manage the consequences of being rejected and enhancing the sense of 'I belong', nurses utilised 'play safe' mechanisms; for example, being bound to hierarchical power, cooperating, and compromising their own needs and feelings for the sake of maintaining harmony. What make the findings unique to this group of participants is that the 'play safe' mechanism was utilised by nurses irrespective of age or years of work experience. This study has highlighted many factors that influenced Malaysian

nurses' sense of belonging. It is important to acknowledge that Malay culture influenced the findings in this study. The values of collectivism were repeated in most of the participants' stories. A nurse's recognition of, and responsiveness to, the action in the workplace is impacted by the hierarchical power and values of Malay culture. Next, the implications are made clear by presenting the conceptual framework that emerged from the study.

8.4 Conceptual framework

Conceptual framework has been defined as a network of interlinked concepts that provide a comprehensive understanding of a phenomenon or phenomena (Jabareen, 2009). In other words, it links existing knowledge and generated knowledge. It can be easily understood as it relates to the "way things are", "the nature of reality", "real existence", and "real action" (Guba & Lincoln, 1994). Therefore, a conceptual framework was based on the reality of life, in this context, the reality of Malaysian nurses' sense of belonging. The aim of the conceptual framework presented in this chapter is to add to the existing body of knowledge by identifying what is already known about belongingness in the workplace and what has been generated through the current study.

Nurses' sense of belonging was enhanced through acceptance received from nursing colleagues and the other health care team members. Under the influence of the nature of nurses' work, the Malay culture, and the traditional hierarchical organisation model, nurses secured their acceptance with colleagues, the other health care team members and the organisation through:

i) maintaining group harmony where nurses cooperate and compromise to group needs rather than personal satisfaction, including the nurses' practice of 'do not rock the boat' behaviour and just following the flow of the ward

ii) working together as a team whereby, in keeping with the nature of nurses' work, they relied on each other to provide physical and emotional support when needed. Therefore, they always offered help, even if not requested

iii) being valued by showing they appreciated other people's opinions and suggestions and being friendly and helpful to colleagues

iv) being obedient where nurses adhered to ward rules and always followed the instructions that have been given, and

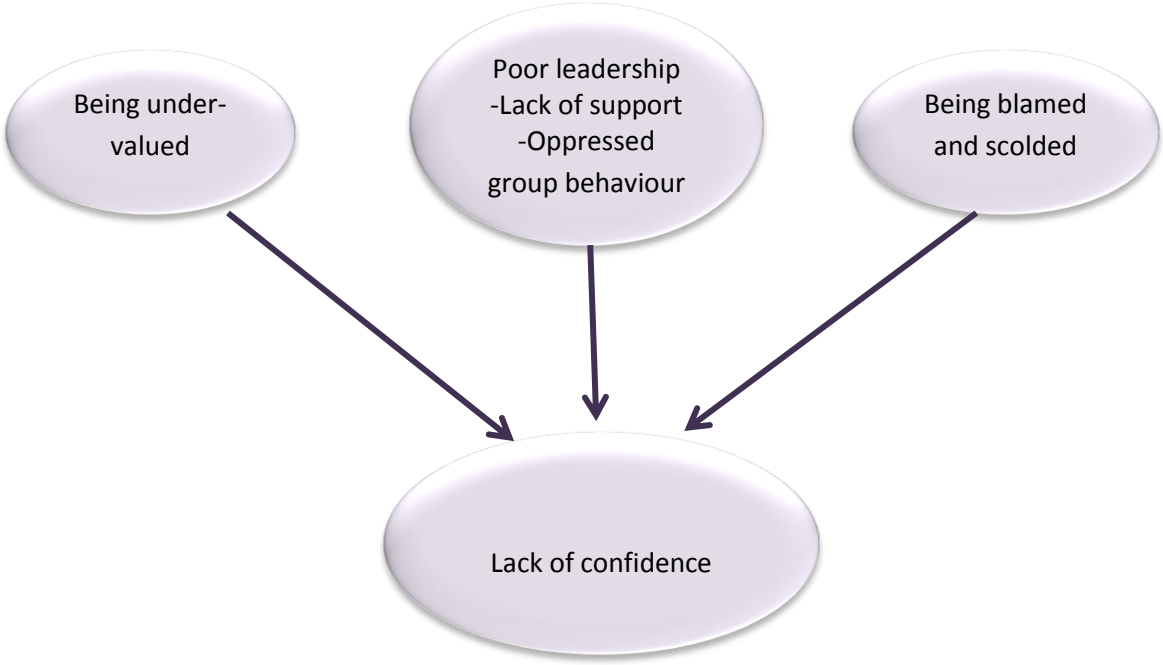
v) being respectful, where nurses showed their respect to colleagues, especially senior colleagues and people in authority.

Figure 8.1 is a diagram of how nurses in this study created their sense of belonging through the influence of the nature of their work, the traditional hierarchical organisation model and the Malay culture.

Figure 8.1: Creating a sense of belonging

Nurses also mentioned factors that hindered their sense of belonging, including being undervalued and lacking control while performing nursing care; for example, being reminded that they were subordinates when implementing ward policy, being blamed and scolded in front of patients or relatives, even though they had not made the mistakes personally, not being given opportunities to explain situations when things went wrong, and not receiving enough support from their own nursing leaders. In this study, sense of belonging had a strong relationship with intrinsic feelings, which included feeling motivated, feeling confident and having job satisfaction. Of these three intrinsic feelings, sense of belonging had the highest impact on feeling confident. Therefore, when nurses felt their sense of belonging was low, it would jeopardise their intrinsic feelings, especially that of feeling confident. Figure 8.2 illustrates factors that hindered a sense of belonging and its major implications.

Figure 8.2: Factors that hindered sense of belonging and the major implications



In light of the findings of this current study, there are a number of recommendations that suggest a way forward for hospitals at different levels of management. The recommendations are divided into three parts, and include recommendations for practice, nursing leadership, and for future research.

8.5 Recommendations

The findings derived from this study clearly highlight some turbulence in the nurses' workplaces. Of primary importance is the practice of respecting seniors or people in authority and compromising to maintain harmony, which does not promote a genuine sense of belonging. Instead, the cooperation and willingness should come from the feeling of "I belong" and not "I need to belong". Accordingly, recommendations involve improvement for practice, nursing leadership and future study.

8.5.1 For health care policy

Working together in inter-professional teams in health care organisations requires the participation of all members. Being person-centred, finding ways of working together in a team, and maintaining effectiveness have been proposed as means of creating a positive workplace culture (McCormack, Manley & Titchen, 2013), and involve all individuals in the team regardless of rank or position. It is well known that each discipline in the health care professions carries its own culture, which includes values, beliefs, attitudes, customs and behaviours (Hall, 2005). Each discipline also carries different knowledge bases according to the needs of the profession. Therefore, each team member must be familiar with, and acknowledge the expertise and functions of, others' roles. Due to the different values and knowledge that every discipline has, health care teams need to always rely on each other from different disciplines to deliver patient care. The World Health Organisation (WHO, 2010, p.

7) defined collaborative practice as ‘when multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care’. During collaboration, the practice allows health workers to engage with any individual from the health care team whose skills can help achieve local health goals (WHO, 2010).

To improve collaboration within the health care team, inter-professional education has been proposed to enhance understanding among health care team members. According to WHO (2010), inter-professional education occurs when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes. Perhaps the power of hierarchy that is strong in Malaysian culture and health organisations could be managed in this way. Such inter-professional education should take place during the academic years and as continuing education for qualified health care professionals. Once students are exposed to the concept and understand the concept of working together inter-professionally, they will likely enter the workplace as a member of a collaborative team which values other disciplines’ strengths, and knows how to optimise the skills of team members from different disciplines, and, together, can manage care to provide better health services to patients and communities. Inter-professional collaboration will hence promote acceptance and genuine respect for each other’s role.

Hierarchical power, which is largely embraced and hidden in the workplace culture, particularly in the healthcare settings in Malaysia, has influenced nurses’ actions and reactions for decades. Indeed, it has been practised for too long and that makes it challenging to dispel its effects. Given that many hospitals in Malaysia practice on the traditional British nursing model (Department of Higher Education, 2010), where the authority of ‘Matron’ and ‘Sister’ are clear, there needs to be a review of how health and nursing care is delivered and

practised. Possibly, practice development work through values clarification can be practised among all health care workers to develop a common shared vision and purpose. Values clarification is a starting point for cultural change, as values and beliefs are known to influence behaviour (Manley & McCormack, 2003). Putting values and beliefs into practice involves overcoming a number of barriers that exist in both the workers and the workplace culture. This can be initiated by clarifying the value of working together among health care team members. Statements that contain values and beliefs like "I believe the purpose of teamwork is to …", "I believe the factors that enable effective teamwork are …", or "I believe the factors that inhibit effective teamwork are …" can help in clarifying the values of each discipline.

Recommendations for policy makers can be summarised as:

- Introduce inter-professional education into undergraduate health care professional courses and as continuing education for qualified health care professionals.
- Undertake a review of how health and nursing care is delivered and practised in the clinical area, for example, through values clarification.

8.5.2 For nursing leadership

The influence of nursing leaders is crucial to nurses' experiences of belongingness. From the nurses' stories, support from nursing leaders seemed lacking and created further barriers to belonging. Because the power of the hierarchy was strong, nurses in this study, regardless of whether they were new graduates or experienced nurses, reported that they sometimes lost to the power of the medical hierarchy. Therefore, supportive environments provided by supportive nursing leaders are essential to back up nurses' emotions, as they have a responsibility to address inappropriate behaviours and show concern for nurses. Maintaining links with subordinates has been proposed as one effective strategy to provide supportive environment (Davies, 2013). Making themselves visible to the ward environment brings

strong relationships through working and learning together, building trust, understanding problems in real situations, and reducing their authority and power as nursing leaders working, learning and listening to each other. This can be a remedy for nurses in Malaysia, as they mentioned that the power of nursing authority was strong and jeopardised their emotions and behaviour.

Nurses must be united and not practise oppressed group behaviour. Providing supportive environments where a sense of belonging exists helps nurses in many ways, including increasing job satisfaction and confidence levels, heightening nurses' emotions, and lowering nurses' intention to leave the workplace or profession. Even though nurses might lose in debating certain issues in the workplace, at least they can be strong due to the support and encouragement they receive from the organisation itself. Nursing leaders must have strong personalities and be smart in managing their own stress levels. This requires thoughtful self-reflection by leaders (Miller, 2012). Self-reflection in nursing leaders' contexts can be described as the willingness of the nursing leaders to learn more about their weaknesses, their strengths, where they make wrong decisions and try to work on how to overcome the problems without blaming another person. Updating knowledge through higher nursing education is also important for nursing leaders to gain respect from nursing staff and other health team members. This is crucial as nurses in this study reported that they lost their respect for their nursing leaders, who, in their opinion, did not have enough positive values to be a leader.

The burden of creating supportive workplace environments should not be shouldered by only those in nursing management. The condition is supposed to be nurtured by every level of staff in the nursing organisation. The importance of supportive environments for nurses is that the support must really make a difference when difficult situations occur; for example, new

graduate nurses feel nervous and lack confidence, and yet not many nursing colleagues give encouragement and support go through the critical new experiences. It is important to remember that a supportive workplace environment is not only essential for novices (Newton et al., 2009), but also for more experienced nurses, as exampled by participants in this study who were being scolded without justice, and being humiliated in front of others for mistakes. It can be concluded that continuous support in the workplace environments is what the Malaysian nurses valued most. Positive connections through positive support will help to enhance feelings of connectedness as defined in the sense of belonging.

8.5.3 Team building

Participants in this study repeatedly emphasised teamwork; they realised they, by nature of their duties, had to rely on each other in patient care delivery. Participants recognised and believed that working alone was not as good as working together. However, instead of collaboration with each other, it was respect, obedience, compromise and toleration that participants in this study used to earn and confirm their teamwork. The teamwork given and the teamwork received did not genuinely come from the spirit of team building. There are many approaches to team building. Based on the participants' experiences in the current study, what seemed to be lacking from people in authority was explanation when they were scolding nurses, and a lack of opportunity for subordinates to explain situations.

In the current study, receiving feedback was what the nurses valued. Rather than continuously receiving negative feedback, nurses also hungered for positive feedback as they believed they were not always making mistakes or not being productive. For both people in authority and the nurses, accepting constructive feedback in a positive, non-defensive manner is crucial. What has been reflected in the current study is that leaders always liked to use their authority as their defence mechanism, reminding the subordinate about their power. As the nurses, in

turn, perceived they were subordinates and were influenced by the culture of 'high power distance', they kept their dissatisfaction close to their hearts. This unpleasant situation might not be very easy to change, as it has been practised for years before. However, if the nursing organisations can start to build positive thinking and cohesive teams within nursing communities, it might help nurses to reach their sense of belonging. With improved inter-staff relationships, nurses will become more comfortable to voice opinions and suggestions, do problem solving together and work more effectively in a team. As in any supportive workplace environment, nursing leaders need to ensure that the team building is an on-going activity.

Recommendations for nursing leaders can be summarised as:

i) Soften the authority

- Be visible to staff and ward environment – work and learn together, and listen to each other
- Provide explanation and feedback to staff – where staff made mistakes, explain how it should be done, providing both positive and negative feedback
- Practice self-reflection – learn about one's weaknesses and strengths

ii) Strengthen knowledge base by updating to current and higher knowledge levels.

8.5.4 Moving forward

The current study only involved two hospitals in the capital city of Malaysia. It is recommended that the study be replicated on a larger scale. Further research using multiple sites, including rural as well as urban hospitals, and using multiple hospital settings including government, teaching, and private hospitals, would further reveal how nurses experience the concept of belongingness and its influences on nurses' intrinsic feelings. As this study

concentrated on registered nurses, additional research specifically related to nurse leaders might provide a different viewpoint from a leader's perspective. A second recommendation is to explore belongingness using an Eastern-focused questionnaire. As this current study used a Western set of questionnaires, it may have influenced conflicting data on Malaysian nurses' belongingness experiences.

Recommendations for future study can be summarised as:

i) Replicate this study on larger scale

- using multiple sites, including rural and urban hospitals
- using multiple hospital settings, including government, teaching and private hospitals.

ii) Replicate this study among nursing leaders to get a different perspective

iii) Develop and use a survey tool that is culturally appropriate for the Malaysian/Asian population.

8.6 Personal interpretation and reflection

Being involved in the nursing profession for more than twenty years made me realise how important nurses are in the health care setting. Belongingness has been a significant interest for me for many years as I wanted to explore the roots of the nursing situation in Malaysia. During this study, as a researcher, the thoughtful and reflective stories by participants revealed how the lack of sense of belonging phenomenon has significant implications for the nursing profession. The hidden experiences of nurses participating in the current study were both surprising and worrying, as there appeared to be a significant urge to speak, yet hidden behind a 'do not rock the boat' mind set. As more personal stories were heard, particularly from the interviews, the amount of negativity reflected by nurses was disturbing. Consequences of the lack of sense of belonging have been brought to life by not only newly-

graduated nurses, but also by senior nurses, which makes the findings more disconcerting. As the nursing profession works with humans, mistakes can occur during nursing care, but it seems that the feedback individuals received was more likely to have been negative, rather than at least *sometimes* positive, and not in a context of no-blame. This shows how the nursing profession in Malaysia has been severely undervalued.

The pressures between generations and between nursing hierarchies were also intense. Instead of supporting and caring for each other, the participants were more directed towards blaming each other. Nursing, well-known to be a caring profession, has not been successful in caring for nurses, which has led to conflicting values and a lack of belongingness. This situation needs attention if nurses want to improve the nursing profession. Participants' stories influenced me to reflect on my own career in the clinical workplace, and I do not want my experiences to be replicated by other nurses in future.

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Appendices

Appendix 1: Questionnaire

BELONGINGNESS: MALAYSIAN NURSES' EXPERIENCE OF THE CONCEPT

You are invited to complete this important survey of belongingness.

This survey is structured in FOUR sections:

A. **Information about you**
B. **Information about belongingness in your clinical experiences**
C. **Information about your feelings in the clinical workplace**
D. **Your strategies to belong**

Section A: Information about you

Instruction: For each question, please tick (√) the most appropriate answer

1 What is your ethnicity?
- □ Malay
- □ Chinese
- □ Indian
- □ Other (please specify) _____

2 Gender
- □ Male
- □ Female

3 How old are you?
- □ 20 – 24 years
- □ 25 – 29 years
- □ 30 – 34 years
- □ 35 – 39 years
- □ 40 – 44 years
- □ > 45 years

4 Where did you do your basic nurse training?
- □ Ministry of Health
- □ Ministry of Higher Education
- □ Other (please specify) _____

5 What is the highest level of nursing education you have achieved?
- □ Diploma
- □ Bachelor Degree
- □ Master Degree
- □ PhD

6 How many years of nursing experience have you had since graduating from basic nursing?
- □ < 6 months
- □ 6 months – 1 year
- □ 1 – 2 years
- □ 2 – 3 years
- □ 3 – 4 years
- □ 4 – 5 years
- □ > 5 years

7 How many years of nursing experience have you had working in this current clinical area?
- □ < 6 months
- □ 6 months – 1 year
- □ 1 – 2 years
- □ 2 – 3 years
- □ 3 – 4 years
- □ 4 – 5 years
- □ > 5 years

Instructions for Section B and C:

- Please read each statement and then select the response that best indicates how often the statement is true for you
- Please answer every item, even if one seems similar to one another
- Answer each item quickly, without spending too much time on any one item

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Section B: Belongingness Scale Experience in the Workplace
In the statements below:

- **'clinical experience'** refers to your experience as a graduate nurse working in a clinical area providing nursing care to patients, and
- **'colleagues'** refers to nursing staff whom you work with in your clinical area, and
- **'other health care team members'** refers to other staff (e.g. Dr, Pharmacist, Dietitian etc.) whom you work with in your clinical area, and
- **'organisation'** refers to the hospital which you are currently working with.

BIL	COMMENT	LIKERT SCALE			
		Strongly disagree	Disagree	Agree	Strongly agree
1	I feel like I fit in with my colleagues	1	2	3	4
2	It is important to feel accepted by my colleagues	1	2	3	4
3	It is important to maintain the acceptance I received from my colleagues	1	2	3	4
4	Colleagues see me as a competent person	1	2	3	4
5	Colleagues offer to help me when they sense I need it	1	2	3	4
6	I make an effort to help new students or staff feel welcome	1	2	3	4
7	I view my clinical workplace as a place to experience a sense of belongingness	1	2	3	4
8	I get support from colleagues when I need it	1	2	3	4
9	I am invited to social events outside of my clinical workplace by colleagues	1	2	3	4
10	I like working with my colleagues	1	2	3	4
11	I feel discriminated by my colleagues at my clinical workplace	1	2	3	4
12	I offer to help my colleagues, even if they don't ask for it	1	2	3	4
13	I invite colleagues to eat lunch or dinner with me	1	2	3	4

BIL	COMMENT	LIKERT SCALE			
		Strongly disagree	Disagree	Agree	Strongly agree
14	Colleagues ask for my ideas or opinion about different matters concerning the workplace	1	2	3	4
15	I ask for my colleagues' advice about patient care	1	2	3	4
16	Feeling "a part of things" is one of the things I like about working in the clinical area	1	2	3	4
17	I like where I work in the clinical area	1	2	3	4
18	It seems that my colleagues like to work with me	1	2	3	4
19	I feel free to share my disappointments with at least one of my colleagues	1	2	3	4
20	When I come to work, I feel welcomed by all staff	1	2	3	4
21	I feel I fit in with other health care team members where I work	1	2	3	4
22	It is important to feel accepted by other health care team members	1	2	3	4
23	It is important to maintain the acceptance I received from other health care team members	1	2	3	4
24	Other health care team members see me as a competent person	1	2	3	4
25	I am invited to social events outside of my clinical area by other health care team members whom I work with	1	2	3	4
26	I feel respected by other health care team members where I practice	1	2	3	4
27	I get along well with other health care team members at my workplace	1	2	3	4
28	I have good teamwork with other health care team members	1	2	3	4
29	I feel discriminated by other health care team members at my clinical workplace	1	2	3	4
30	I ask for advice about patient care from other health care team members	1	2	3	4
31	Other health care team members ask for my ideas or opinion about different matters concerning the workplace	1	2	3	4

BIL	COMMENT	LIKERT SCALE			
		Strongly disagree	Disagree	Agree	Strongly agree
32	I invite other health care team members to eat lunch or dinner with me	1	2	3	4
33	Being a nurse in a multidiscipline clinical area make me feel like an outsider	1	2	3	4
34	As a nurse, I am uncomfortable attending multidisciplinary social functions at the clinical workplace, as I feel like nursing does not belong	1	2	3	4
35	I feel strongly that I belong to the organisation where I work	1	2	3	4
36	I get adequate opportunities (e.g. promotion, study leave) from the organisation where I work	1	2	3	4
37	I get adequate support (e.g. preceptor ship, orientation) from the organisation	1	2	3	4
38	I respect the administrative people (nursing and others) in my organisation	1	2	3	4
39	My organisation recognises nursing as a profession	1	2	3	4
40	My organisation involves nurses in decision-making	1	2	3	4

Section C: Information about your feelings in the clinical workplace

In the statements below:

- **'workplace'** refers to your current clinical area where you work

Part C (i): Intrinsic motivation

BIL	COMMENT	LIKERT SCALE			
		Strongly disagree	Disagree	Agree	Strongly agree
1	I find my present work personally rewarding	1	2	3	4
2	Without me, my patients would not get the care they need	1	2	3	4
3	What I do every day really makes a difference in my patient's lives	1	2	3	4
4	I am able to provide high quality care to my patients	1	2	3	4
5	My job does not provide me with enough intellectual stimulation	1	2	3	4
6	I feel a strong personal connection with my patients	1	2	3	4

BIL	COMMENT	LIKERT SCALE			
		Strongly disagree	Disagree	Agree	Strongly agree
7	The gratitude displayed by my patients keep me going	1	2	3	4
8	I am having a positive impact on a needy patient who need my care	1	2	3	4
9	I consider nursing as strongly belong to the health care organization	1	2	3	4

Part C (ii): Feeling Confident

BIL	COMMENT	LIKERT SCALE			
		Strongly disagree	Disagree	Agree	Strongly agree
1	I discussed ideas with colleagues, other health care team members, and administrative people	1	2	3	4
2	I give suggestions to colleagues, other health care team members, and administrative people	1	2	3	4
3	I question why we do things the way we do in this ward	1	2	3	4
4	I have a say in making decisions and involved in making decisions	1	2	3	4
5	I feel more confident when somebody appreciates my job.	1	2	3	4
6	I keep silent even if I have something to say	1	2	3	4
7	I give opinions during discussion about patient's care with colleagues and other health care team members	1	2	3	4
8	My ideas and suggestions are used in patient's care	1	2	3	4

Part C (iii): Job satisfaction

BIL	COMMENT	LIKERT SCALE			
		Strongly disagree	Disagree	Agree	Strongly agree
1	Overall, I am pleased with my work	1	2	3	4
2	Overall, I am satisfied in my current practice	1	2	3	4

BIL	COMMENT	LIKERT SCALE			
		Strongly disagree	Disagree	Agree	Strongly agree
3	My current work situation is a major source of frustration in my life	1	2	3	4
4	My work in this practice has not met my expectations	1	2	3	4
5	If I had it to do all over again, I would still choose to work where I do now	1	2	3	4
6	I would recommend nursing career to a student seeking career advice	1	2	3	4
7	I am seriously thinking about leaving my nursing practice	1	2	3	4
8	I stay in nursing mainly because there is no easy way for me to move to another type of work	1	2	3	4

Part D: Strategies to "fit in"

1 What strategies do you currently use to 'fit in' in the workplace with:

a. colleagues?

b. other health care team members?

- Thank you for taking time to complete this survey. Your input is valued and greatly appreciated.

- **Would you consider taking part in the interview session of this research project?**

□ **Yes** □ **No**

- **If your answer is yes, please provide your details in the next page and detached that page from this main questionnaire. Please sealed your personal details in the pre-labeled envelop provided (Belongingness Survey – Interview session)** and sent it via internal mail along with the questionnaire envelope to the designated locked box at Nursing Department. Your application will be randomly selected according to your years of work experience. If you did not receive any feed back from researcher within two weeks after your application, please be advised that other participant with same years of work experience with you has been randomly selected. Thank you so much for your interest and cooperation. It is highly appreciated.

- Please return the **completed questionnaire in the pre-labeled sealed envelope provided (Belongingness Survey – Questionnaire)** and sent it via internal mail to the designated locked box at Nursing Department.

Application to take part in the Belongingness interview session

Name: _____

Years of work experience: _____

Place of working: _____

Contact number: _____

Email address: _____

Appendix 2: Recruitment poster

Staff Nurses Required!

A Study of Belongingness in the Clinical Workplace.

This research project aims to explore Maslow's Theory of Human Needs in relation to a sense of belongingness in nurses' clinical workplace.

You are invited to complete a Belongingness Survey Questionnaire and take part in the interview session. Should you encounter any queries, please contact:

Zainah Mohamed (PhD candidate, Monash University, Australia)

ph: [redacted] email: [redacted] OR

[redacted]

Appendix 3: Participant Information

MONASH University

Participant Information (Staff Nurses)

Project Title: Belongingness: Malaysian Nurses' Experience of the Concept in the Clinical Workplace

1. Introduction

This research project aims to explore Maslow's Theory of Human Needs related to sense of belongingness in nurses' workplace. As a staff nurse, your contribution will assist to determine potential obstacles to this process.

This participant information tells you about the research project. It explains what is involved to help you decide if you want to take part. Please read this information carefully. You will be given a copy of this Participant Information to keep.

2. Definition of belongingness

A deeply personal experience to which an individual feels (a) secure, accepted, included, valued and respected by a defined group, (b) connected with or integral to the group, and (c) that their professional and/or personal values are in harmony with those of the group (Levett-Jones & Lathlean, 2009a). At workplace, the person experience social integration with colleagues and work community and acknowledged by colleagues and other members in organization (Maslow, 2000; Ryan & Deci, 2000).

3. What is the purpose of this research project?

The aim of this study is to interpret the experience graduate nurses involve in seeking belongingness in their clinical workplace. This research might highlight organizational influences which result in barriers to the process of belonging itself. It is expected that approximately 400 staff nurses will take part in answering the questionnaire, and 14 graduate nurses will take part in the interview session. Participants will be sought from two different hospitals located in Kuala Lumpur. The results of this research will be used by the researcher, Zainah Mohamed, to obtain a PhD degree.

4. What does participation in this research project involve?

Participation in this study will involve you completing a questionnaire, and may do also participate in a semi-structured interview regarding your experience of belongingness in your workplace. This interview will be one-on-one and be audio taped.

5. How much time will the research take?

It will take approximately 20 minutes to answer the questionnaire, and approximately 30 - 40 minutes to participate in semi-structured interview, if you choose.

6. What are the possible benefits?

It is hoped that this study will help the nursing profession and the health organization to better understand what nurses' value in their clinical workplace, thus helping in retaining graduate nurses in clinical area.

7. Any inconvenience/discomfort?

There are no physical/psychological stresses, inconveniences or discomfort beyond the normal experience of everyday life anticipated from participating in this study. However, there is minimal inconvenience and/or discomfort for you during time to complete the survey or participate in the interview. The semi-structured questions may make you feel uncomfortable because you are being asked questions regarding your experience of belongingness in your workplace. If you feel upset as a result of your participation in the research, the researcher is able to arrange for counselling or other appropriate support.

8. Can I withdraw from the research?

Being in this study is voluntary and you are under no obligation to consent to participate. If you decide to take part in the interview session, you may be asked to sign the consent form. By signing it you are telling us that you: i) understand what you have read; ii) consent to take part in the interview session; iii) consent to the use of your personal and practice information as described. However, if you choose to participate in this study, it will not be possible to withdraw once you have submitted your answered questionnaire or taken part in answering the semi-structured interview.

9. Payment

No payment or reward is offered to participate in this study.

10. Confidentiality

The results will be reported in a way that no individual can be identified. All data will be coded and reported collated. Qualitative data will be reported using pseudonyms. No person or organization will be reported in any report, publications or conference presentation.

11. Storage of data

Storage of the data collected will be kept on University premises in the School of Nursing and Midwifery. Data will be stored in a locked filling cabinet and on a password-secure computer for 5 years. Only researchers involved in the project will have access to this data.

12. Results

If you would like to be informed of the aggregate research finding, please contact Zainah Mohamed on [redacted] (Australia), [redacted] (Malaysia) or email [redacted] OR [redacted] . The findings are accessible for five years.

If you would like to contact the researchers about any aspect of this study, please contact the Chief Investigator:	If you have a complaint concerning the manner in which this research is being conducted, please contact:
Associate Professor Dr. Lisa Mckenna **Email** [redacted] **Phone** [redacted] **Fax** [redacted]	Associate Professor Dr. Hamidah Hassan Head of Nursing Department Faculty of Medicine Universiti Kebangsaan Malaysia Jalan Yaakob Latiff Bandar Tun Razak 56000 Cheras, Kuala Lumpur Tel: [redacted] Fax: [redacted] Email: [redacted] OR Executive Officer Monash University Human Research Ethics Committee (MUHREC) Building 3e Room 111 Research Office Monash University VIC 3800 Tel: +61 3 9905 2052 Fax: +61 3 9905 3831 Email: muhrec@monash.edu

Thank you for your time.

Zainah Mohamed
PhD. Candidate
Monash University,
Clayton Campus,
Australia.

Appendix 4: Reminder Slip

Reminder Slip!

Do nurses feel they belong in their own clinical workplace?

Help improve nursing quality and retaining graduate nurses!

- Please complete the belongingness survey distributed to you earlier
- It only takes approximately 20 minutes
- Your help is valued for this important study!
- Should you encounter any queries, please contact me, Zainah at [redacted]

Please return the completed survey in the pre-labelled sealed envelope to Nursing department by _____

* Please disregard this reminder if you already send your completed questionnaire

Appendix 5: Interview Protocol

BELONGINGNESS: MALAYSIAN NURSES' VALUE OF THE CONCEPT

This is an in-depth face-to-face semi-structured interview. The interview session will take approximately 30 – 40 minutes.

The aim of the interviews is for nurses to:

- Describe their personal experience of belongingness
- Identify factors influence their strategies to fit in or maintaining their fit in
- Identify any difference in the strategies used to confirm their sense of belongingness

Open-ended questions may take the following forms:

Section A: Demographics information

i. How old are you?

ii. What is your ethnicity?

iii. Gender?

iv. Where did you do your basic training?

v. What is the highest level of nursing education you have achieved?

vi. How many years of nursing experience have you had since graduating from basic nursing? _____ Years.

vii. How many years of nursing experience have you had working in this current clinical area? _____ Years.

viii. How long exactly have you worked for this hospital?

Section B: Belongingness experiences

i. What is your understanding of belongingness?

ii. How well do you feel you belong in your workplace?

iii. What factors influence your perceptions?

iv. Can you describe your experience at workplace (situation or particular time) when you felt as if you were:

a. part of the team members?

b. **NOT** part of the team members?

v. Are there any factors that inhibit your sense of belonging in the workplace?

vi. Have you ever thought of leaving nursing? If so, why?

vii. What would you want to see changed to enhance your sense of belongingness?

Appendix 6: Consent Form for Interview Session

MONASH University

Consent Form (Staff Nurse)

Title: ***Belongingness: Malaysian Nurses' Experience of the Concept in the Clinical Workplace***

NOTE: This consent form will remain with the Monash University researcher for their records

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Participant Information, which I keep for my records. I understand that agreeing to take part means that:

I agree to be interviewed by the researcher ☐ Yes ☐ No

I agree to allow the interview to be audio-taped ☐ Yes ☐ No

- I understand that my participation is voluntary, that I can choose not to participate in the interview session, and that I can withdraw before taken part in interview without being penalised or disadvantaged in any way.
- I understand that any data that the researcher extracts from the interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.
- I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party.
- I understand that data from the interview will be kept in a secure storage and accessible to the research team. I also understand that the data will be destroyed after a 5 year period.

Participant's name: _____

Signature: _____

Date: _____

Appendix 7: EPU Approval to Conduct Research In Malaysia

UNIT PERANCANG EKONOMI
Economic Planning Unit
JABATAN PERDANA MENTERI
Prime Minister's Department
BLOK B5 & B6
PUSAT PENTADBIRAN KERAJAAN PERSEKUTUAN
62502 PUTRAJAYA
MALAYSIA

EPU

Telefon : 603-8872 3333

Rujuk Tuan: Your Ref.:

Rujuk Kami: Our Ref.: UPE: 40/200/19/2769

Tarikh: Date: 24 March 2011

Zainah Mohamed
A-12-03a, Lestari Apartment,
Jalan Tasik Permaisuri 3,
Bandar Tun Razak
Cheras,
56000 Kuala Lumpur.
Email: [redacted]

APPLICATION TO CONDUCT RESEARCH IN MALAYSIA

With reference to your application, I am pleased to inform you that your application to conduct research in Malaysia has been *approved* by the **Research Promotion and Co-Ordination Committee, Economic Planning Unit, Prime Minister's Department.** The details of the approval are as follows:

Researcher's name :	**ZAINAH BINTI MOHAMED**
Passport No. / I. C No:	[redacted]
Nationality :	**MALAYSIAN**
Title of Research :	**"BELONGINGNESS: THE VALUE AMONGST GRADUATE NURSES"**

Period of Research Approved: **3 YEARS**

2. Please collect your Research Pass in person from the Economic Planning Unit, Prime Minister's Department, Parcel B, Level 4 Block B5, Federal Government Administrative Centre, 62502 Putrajaya and bring along two (2) passport size photographs. You are also required to comply with the rules and regulations stipulated from time to time by the agencies with which you have dealings in the conduct of your research.

3. I would like to draw your attention to the undertaking signed by you that you will submit without cost to the Economic Planning Unit the following documents:

a) A brief summary of your research findings on completion of your research and before you leave Malaysia; and

b) Three (3) copies of your final dissertation/publication.

4. Lastly, please submit a copy of your preliminary and final report directly to the State Government where you carried out your research. Thank you.

Yours sincerely,

(**MUNIRAH ABD. MANAN**)
For Director General,
Economic Planning Unit.
E-mail: [redacted]
Tel: [redacted]
Fax: [redacted]

ATTENTION

This letter is only to inform you the status of your application and **cannot be used as a research pass**.

Cc:

Ketua Setiausaha
Kementerian Kesihatan Malaysia
Bahagian Dasar dan Hubungan Antarabangsa
Aras 6, 8 & 11, Blok E7, Kompleks E
Pusat Pentadbiran Kerajaan Persekutuan
62590 Putrajaya
(u.p: Puan Abidah Binti Harun Alias)

Appendix 8: Monash Ethics Approval

MONASH University

Monash University Human Research Ethics Committee (MUHREC) Research Office

Postal – Monash University, Vic 3800, Australia Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton
Telephone +61 3 9905 5490 Facsimile +61 3 9905 3831 Email muhrec@monash.edu
www.monash.edu/research/ethics/human/index/html ABN 12 377 614 012 CRICOS Provider #00008C

Human Ethics Certificate of Approval

Date: 19 May 2011
Project Number: CF11/1379 – 2011000763
Title: Belongingness: Malaysian Nurses' experiences of the concept in the clinical workplace
Chief Investigator: Assoc Prof Lisa McKenna
Approved: From: 19 May 2011 To: 19 May 2016

Terms of approval

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, and a copy forwarded to MUHREC before any data collection can occur at the specified organisation. **Failure to provide permission letters to MUHREC before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research**.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. **Amendments to the approved project (including changes in personnel):** Requires the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

Professor Ben Canny
Chair, MUHREC
cc: Dr Jennifer Newton, Mrs Zainah Mohamed