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Development of a Positive Professional Identity: Liberating Oneself from the Oppressor Within

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Abstract

Although oppressed group behavior has been discussed as important for empowering nurses, little has been written about the process of liberation from oppression. One of the major factors that keeps the oppressed from becoming empowered is poor self- and group esteem and identity. This article explores models of positive identity development from other oppressed groups and explores their relevance for nursing. A model is created, based on the other models, which proposes a process for nurses as they begin to understand their oppression and develop more positive images of themselves and other nurses.

The true focus of revolutionary change is never merely the oppressive situations which we seek to escape, but that piece of the oppressor which is planted deep within each of us. 1(p123)

Over the last two decades, nurses have explored models of oppressed group behavior for their implications for nursing. 2-8 These models explain that powerless groups have difficulty taking control of their own destiny because internalized beliefs about their own inferiority lead to a cycle of self-hatred and inability to unite to challenge the inequality of power. Empowerment of these groups involves the development of a more positive self-image through understanding of the cycle.

This article proposes a model of identity development for nursing based on models of other oppressed groups. 9-13 An understanding of the stages through which others have passed to create positive identities can be helpful to nursing. The creation of such a model is part of the exploration of how nurses, traditionally powerless, can develop authentic and positive professional identities.

Outline

A more positive professional identity can lead to greater unity, purpose, and empowerment. Although a positive identity is not alone sufficient for empowerment, it breaks the cycle of oppression and leads to changes in the structures that oppress nurses and their patients.

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OPPRESSED GROUP BEHAVIOR

An understanding of oppressed group behavior developed from observations of the experiences of colonized Africans, 14-17 South Americans, 18 African Americans, 19 Jews, 20 and American feminists. 21 Freirel 18 created his model of oppression based on his work with Brazilians who had been taken over and dominated by Europeans. He found that subordinate groups learn to hate themselves and their attributes (eg, skin color, language, clothing, food) because the dominant group is able to set the norms for what is valued. Over time, these values become internalized as part of the culture.

Miller 21 noted that this process in American women led to a devaluation of their worth and development of poor self-esteem because they were not like the valued persons in society-men. She also notes that the dominant group defines "one or more acceptable roles for the subordinate … which typically involves providing services that no dominant group wants to perform." 21(p6) Those members of the oppressed group who attempt to succeed can do so only by attempting to act and look as much as possible like the dominant group, which is often impossible (eg, change skin color or gender). Lewin 20 called these persons "marginal" because they deny their own characteristics but are not authentic members of the dominant group. These persons attempt to "pass," but feel shame, self-hatred, and disapproval of their own group. 17 These negative feelings, as well as frustration with their powerlessness, lead to internal conflict in the group. 18 The group, therefore, is not able to unite to fight against the powerful group and develops a passive-aggressive approach to dealing with the oppressor.

Freire 18 suggested that the maintenance of oppression is achieved by an educational system that reinforces the belief that the dominant group's characteristics and abilities are the most important. Over time, both groups believe that the oppressed have always been inherently inferior, and the history of the development of the hierarchy becomes lost. The system is also maintained by rewarding those in the oppressed group who support the dominant views and values. 19 Jobs, financial support, and privileges are awarded to those in the oppressed group who work to maintain the status quo and who quell any revolt that might begin. Persons who strive for increased status in the society are capable and intelligent and represent the leadership of the subordinate group. The group therefore has difficulty in establishing a balance of power because its leadership is "marginal."

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POSITIVE IDENTITY DEVELOPMENT

Freire 18 developed strategies for liberation from oppression. The first step in the process is to understand the cycle and to expose the myths that maintain the hierarchy. The oppressed need to develop an individual and collective positive self-esteem through a renewed appreciation for their own history and attributes. The group must actively seek autonomy through a grass-roots organization because the oppressor or their own leadership is invested in maintaining the status quo. Consciousness-raising groups, for example, were instrumental for White feminists in the 1960s and 1970s as a vehicle for exploring the myths of male dominance. African Americans have explored their ancestral beliefs and history as a way of understanding their identity prior to slavery. The slogan "Black is beautiful" is another example of a mechanism used to reverse negative self-image.


Table 1


Table 1

Several authors have described stages that African Americans have gone through as they move from identifying as "Negroes" who sought white approval to "Blacks" with authentic self-image. 9,10,12,13 The Cross 9 model will be described because it represents an early and characteristic model (Table 1). The first stage in this model, *Preencounter*, describes the person who is accepting of and comfortable with his or her oppressed status. The person supports assimilation and struggles to deny race and the stigma of it.

The second stage, *Encounter*, involves experiencing an event that causes a change in the way the person interprets the world. An event occurs that profoundly alters the person's reality and causes him or her to test out a new way of thinking. The person begins to question his or her assumptions about the world and to feel anger about his or her oppression. Cross 9 suggested that the death of Martin Luther King, Jr., was such a catalyst. The civil rights movement, Afro-centric education, and education on racism also have served as catalysts. 13

The third stage, *Immersion-Emersion*, develops because people need to be apart from the dominant culture and supported by their own group while they begin to test, understand, and absorb their new reality. During this stage, the persons immerse themselves in the study of their heritage, their culture, and the injustices brought about by oppression. This study and discussion with others build affirmation and strengthen a positive identity. This phase, not surprisingly, involves a preference for being with other Black persons. There develops an increase in anger toward Whites and a belief that Blacks are superior and Whites are defective. This phase creates an increased openness to views not previously explored and an increased sense of authentic self-pride.

The fourth stage, *Internalization*, signals the beginning of the end of the conflict between the old and new identity. The person has a new confidence in his or her "blackness" and an ability to once again interact with Whites without as much overt anger. An ability to collaborate and mingle with other groups returns but with a new sense of self-confidence and pride brought to the interaction.

The last stage, *Commitment*, involves translating the new perspective and identity into an active role working within the group to improve the minority community and expand social justice in general.

Downing and Roush 11 analyzed the implications of this model for their work as counselors of women (see Table 1). The model of feminist identity that they developed had four stages, which paralleled those of the Cross model. The first stage, *Passive Acceptance*, describes the woman who is unaware of any individual, institutional, or cultural discrimination against her or other women. There is an acceptance of the traditional role of women and a view that there are distinct advantages to their subordinate role. The counselors noted that toward the end of this phase women begin to develop a receptivity to another view that they call "readiness."

The second stage, *Revelation*, occurs with a realization of discrimination against women precipitated by reading, taking a class, therapy, a divorce, or an instance of discrimination that cannot be denied (eg, denial of credit, loss of promotion or a job opportunity). Downing and Roush 11 noted that this process for women may be slower and more filled with doubt and mistrust than for Black Americans because of the lack of the same kind of specific, visible, and obvious societal discrimination on a large scale. This learned behavior of distrusting themselves and other women creates self-doubt and a hesitancy to move into the third stage. Women also are often dependent on men for income, housing, and family support, which makes them hesitant to make any major change.

The third stage, *Embeddedness-Emanation*, involves an interest in and

dedication to other women and their lives. In this stage, women develop closer emotional ties with other women, increased anger about their world, and a belief in the inherent superiority of women. The work of this stage is to develop the beginning of a new identity in an environment that is supportive to their reflection and new ideas. This experience causes dissonance for many women, as it often means an emotional separation from their husbands, families, and the lives that they have always known and depended on.

The fourth stage, *Synthesis*, involves the integration of the new identity and world view into the life of the woman. At this point she is able to transcend the traditional sex role stereotypes, the anger and dichotomous thinking of the third stage, and truly develop what Miller 21 describes as her "new way."

The fifth stage, *Active Commitment*, involves the use of the new world view to work for social change. The authors suggest, as did Cross about African Americans, that most women do not evolve to this stage and that many women who are actively involved in the women's rights movement may still be evolving through the third or fourth stage.

Both theories, as is the case with most stage theories, are presented in the linear fashion for clarity but in reality involve movement back and forth across stages. There is an assumption that persons may stagnate or "recycle" through stages or may need to revert to earlier stages if the transition is too stressful or painful, or their experiences or their environment changes. 11 The theory does, however, provide a developmental framework to help individuals, their teachers, counselors, and loved ones to understand their behavior as a positive evolution.

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NURSES AS AN OPPRESSED GROUP

Nursing, because of its lack of power and control except in its own group, has been viewed as an oppressed group. 3-8,22 Allen and Hall 23 explained that the values of nursing are rarely recognizable in patient care because the values of medicine and the medical model have been internalized as most appropriate. The identity of nursing has been subsumed by medicine, which claims all of health care as its domain. Nursing and the larger society have accepted the biomedical approach to health care as the most important. Certain tasks, however, are relegated to nursing and other disciplines as it is useful. A more recent study documented that, despite role changes in the 1990s, nurses still felt that they were devalued and viewed as "handmaidens" as a result of managerial and medical domination. 24

Nurses have also been noted to have the characteristics of other oppressed groups. 2-8,24 Lack of self-esteem 25,26 and passive aggressiveness 27,28 have been cited as personality characteristics commonly found in nurses. Leaders of nursing have been viewed as an elite and marginal group that have been rewarded for maintaining the status quo. 5,7,8,22 Grissum and Spengler 29 noted that nursing leaders often view themselves as better than their own group and support the work of the dominant group even if it means dependency for the nurses. Although many feel that nurses have made great progress over the last two decades, McCall 24 found that staff nurses in the 1990s described examples of behaviors consistent with the Freire model, especially "horizontal violence" from nursing supervisors. Gordon 30 also recently stated that she has been "struck by the negative messages nurses broadcast to one another" as she has observed them. She explains her concern about this self-hatred: "I would argue that nurses need to stress their strengths and move forward based on an analysis and appreciation of those strengths. But to harp on this concept of self-enmity impedes its forward motion and conveniently ignores who the real enemies of nursing are." 30(p63)

Chandler 31 has observed that nurses lack a public "voice" that describes the

contribution of nursing actions to the care of patients. She observes that conversations are most commonly between nurses or between a nurse and her patients, but that nurses rarely talk about their work in public. Many also express the opinion that nurses have been derogatory about each other and nonsupportive in work settings. DeMarco 32 found that staff nurses tended to "silence" themselves in order to maintain the culture of the workplace.

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LIBERATION FOR NURSING

The first step in liberation from oppression is to understand and talk about the dynamics that have perpetuated the system. This awareness is often freeing and helps nurses to understand behaviors that have frustrated and confused them. Lynaugh and Fagin 33 have called for a renewed sense of pride and celebration from analyzing the history of nursing:

This confluence of paradoxes, problems, and characteristics of nursing development can be responded to in two ways. One is to bewail our failures and accept the inevitability in the face of an historically hostile environment. The other is to wonder at and celebrate the accomplishments of nurses, mostly of the wrong sex and class, who have the wrong history and education, who persist and achieve in spite of being held back by some of the most powerful forces in our society. 33(p184)

Development of personal and professional pride begins to reverse the cycle of low self-esteem and internalized hostility that has led to divisiveness and lack of progress. This realization comes about through a personal and group re-analysis of common experience in light of knowledge of the dynamics of oppression. As Gordon has suggested, "To build community, self-esteem and to truly understand the past and change the present, I think nurses have to jettison the old mantras, and re-examine reality, and reaffirm their considerable strengths." 30 Chandler 31 has suggested that nurses reexamine their own "self-voice," look for messages that are self-destructive, develop a new positive voice, and take it public. "We can no longer restrict our conversations to the private space of patients and peers. Nursing work is too valuable to go quietly unexpressed." These processes of rediscovery assist nurses to understand the dynamics of the system and to behave differently because of their new understanding.

The leadership of nursing also needs to be explored. In the 1990s, the stuggle against oppression for nursing executives was especially complex. 7 Although they need to develop a cohesive nursing group, many nursing leaders have become "marginalized" and separated from the staff nurse. Recent changes in health care organizations have focused on cost savings rather than innovation in nursing care. The increase in decentralization of nursing care into the community and use of non-nursing personnel have led to an emphasis on survival rather than on introspection.

Nursing organizations have traditionally been hierarchical, with administrators and educators rising to positions of leadership. 7 This development has been partially related to education and class, but also to the ability of these groups to be available for meetings-to have time within their workday to travel to conferences and do committee work. The unionization of nursing has created grass-roots organizing, but it is often viewed by the traditional nursing leadership as nonprofessional and has led to further division within nursing. The profession therefore has a dilemma of how to develop a cohesive group. Nursing includes individuals from varied educational and class backgrounds, many of whom work part time and have multiple other roles (eg, mother, wife) that consume time and energy and decrease the ability to be active outside of the workplace. Unpaid professional work is difficult to fit into the life of many staff nurses.

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POSITIVE IDENTITY DEVELOPMENT FOR NURSING

Nurses also have a variety of different world views. Personal identity and an understanding of the world exist before nurses enter the profession. Age, gender, ethnic identity, and family/life experiences are varied and have taught the beginning nursing student a way of looking at the power structure and dynamics of the world in which he or she lives. Socialization as a nursing student, prior experiences, and work as a nurse all combine to develop the assumptions and beliefs about how to behave as a professional. These three merge into a professional identity that continues to develop and change throughout the career.


Table 2

Although nursing has been viewed as an oppressed group, there has not been discussion of identity development of nurses similar to that written about other oppressed groups. There has been little discussion of the varying world views of nursing and the process through which they evolve. Such a model suggests how nurses change from being unaware of their history of oppression to a commitment to create a more egalitarian system. Although there is no research that exists in this area, a model is proposed based on previous writing and informal observations (Table 2).

The first stage, *Unexamined Acceptance*, represents the passive acceptance of the dominant view without any exploration of other alternatives. Nurses in this stage may complain about, but accept, the role of nurses as subservient in the system and do not question the rightful dominance of the medical model. Their view of other nurses may be negative. A nurse in this stage may be heard saying such things as "nurses are their own worst enemies" or "nurses eat their young" or "what can you expect from a group of nurses?" These nurses may be eager to attend professional gatherings but prefer non-nursing functions. These persons may participate in professional groups but carry into that group a commitment to working on issues that will not change the status quo of the power structure. These nurses are overly critical of themselves and their performance and readily accept blame in situations where others were also responsible. Many of the "marginal" nursing leaders who express a great deal of disdain for the inability of nursing to "just take charge and get it done" are in this stage. Often these nurses combine their dislike of nursing with their distrust of women in general, that is, "the problem with nursing is that it is mostly women." Nurses in this stage express disbelief in the relevance of the theory of oppression and feel that "nurses can get ahead if they would just work at it."

The second stage, *Awareness*, involves a beginning understanding of the power structure and the myths that support it. Many women who have been active in the social justice, civil rights, or the feminist movement come into nursing with this view. In fact many who come into nursing with this understanding express frustration with nursing and may even leave because of an inability to relate to the dynamics of the work world. Others move into academic nursing where the overt power differences are less obvious and where there is more tolerance for their views. Movement into this stage happens with an experience of injustice as a nurse or prior to entering nursing that cannot be rationally explained. It may be a reprimand for speaking up or a loss of a job or a promotion for themselves or a valued colleague. The change may also occur because of an experience with power dynamics while working with a professional group toward political change. Often this realization occurs when the nurse steps out of the practice arena to return to school. Outside of the institutional environment, the student role can allow for the opportunity for reflection on and exploration of their work world and the forces that influence it. In this stage there is often anger at institutions, physicians, and nursing leaders that can be expressed in a supportive environment with like-minded nurses. This is a phase in which the discussion is very dualistic, that is, all nurses are good, caring, and intelligent, and all physicians are entitled, overpaid, and underworked. For female nurses this realization may also trigger connections with feminism as they begin to view the world in a different way.

In the next stage, *Connection*, nurses make a linkage to other nurses built on

the beginning of a new self and professional identity. The nurse finds groups of nurses to share the emerging positive identity. This is a time of commitment to nursing and a tendency to be isolated from other groups. There is a dependence on other nurses for support and for reaction to the new view. Nurses in this stage become energized to work on committees at work, within professional organizations, or within a union. They develop a new appreciation for each other as they work to change a system they can no longer tolerate. They may appear strident and uncompromising in their attempts to make change. The nurse also talks with family, friends, and coworkers about the injustices in the system and the need for change. Registered nurses who return to school for a bachelor's degree or those who return for graduate study often now feel unsettled in their jobs as they attempt to explain their new insights. They return to their classmates for support and reassurance. Within the group there is a new appreciation of the accomplishments of nurses, but in old arenas there is discomfort.

In the fourth stage, *Synthesis*, the new positive image becomes internalized and feels more authentic. The anxiety of change is replaced with a stability of belief about the ability of one's self and one's colleagues. The anger of the previous stages turns into strategic efforts toward change. The nurse becomes more able to work in interdisciplinary groups and regains an appreciation of the contributions of others. The nurse is able to evaluate coworkers on an individual basis and not merely as belonging to one group or another. Although less obvious, the commitment to and enjoyment of working with other nurses continue but are not as verbal or explicit as in the previous stage.

In the last stage, *Political Action*, a genuine and ongoing commitment to social change occurs. The activities of the nurse involve mobilizing for a more equitable system. This activity is not for nursing alone but represents, as with other groups, a commitment to improvements for society at large. Nurses in this stage are concerned about broader issues of social justice, women's rights, and improvement of patients' lives and health. This phase involves an understanding of the interdependence of groups that make up the society and the need to improve that larger society.

This model is not supported by research data, but rather represents an attempt to describe behaviors based on other writings and informal observation. As with all stage theories, it is assumed that it is not always linear and that individuals move back and forth or stall in various stages. Persons may move back to an earlier stage if the stress of change is too great or circumstances change, or they may go through the whole process again at a future time. The model represents an attempt to describe the phases of development out of oppression. An understanding of the process can guide nurses in a time of change.

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SYSTEMIC CHANGE

Although this article focuses on the development of a positive identity as critical to breaking the cycle of oppression and becoming empowered, it is always intertwined with the need for systemic change to alter the power structure that creates oppression. A focus on individual development does not imply that the behavior and poor self-esteem of the oppressed create oppression, or that they do not fight against it. Hooks 34 has pointed out that Black women in America can be proud of their behavior under oppression. She notes that throughout their long history of sustained and intense domination, these women performed "small acts of resistance" on a regular basis. 34 Recognition of this resistance is important because it emphasizes the strength of dominated groups and acknowledges attempts by the oppressed to avoid victimization. 35 This identification is helpful in overcoming the overwhelming societal messages that the oppressed are inferior and responsible for their own condition. 35

West 36 argues that identity development and environmental conditions are intertwined and react to each other. "First we must acknowledge that structure

and behavior are inseparable, that institutions and values go hand in hand. How people act and lives are shaped-though in no way dictated or determined-by the larger circumstances in which they find themselves." 34(p12) He acknowledges that although the development of a positive identity has been crucial to equality for African Americans, it is not all that is necessary. "The quest for black identity involves self-respect and self-regard, realms inseparable from, but not identical to, political power and economic status." 34(p66) He warns against social policy changes that have seen the problems of African Americans as their self-esteem, therefore avoiding the social injustice that has led to it. He supports changes that attack the remnants of the previous inequality and also address the cycle of oppression.

For nursing as well, the need to analyze and change the systems in which nurses lack power and are devalued are the most important tasks. Nurses need to celebrate their great impact on patient care and their successes as a profession despite the overwhelming forces against them. The importance of utilizing an "internalized oppression" model is to encourage reflection and a change in the cycle of oppression. Change to a more positive identity assists nurses to organize with one another to change the system that oppresses them.

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SUMMARY

This article presents a model for understanding the process of positive identity development for nursing. The model is based on models developed for other oppressed groups. The stages explain how nurses pass from acceptance of their subordinate status in the health care system to a new awareness of the power dynamics of the system and finally into a renewed and positive identity of themselves as professionals. This exploration is useful because it more specifically articulates how nurses break the cycle of oppression. This awareness is useful to nurses, to educators, and to nursing leaders who strive to understand and unite nursing into a more cohesive, effective, and powerful force in the health care system. This focus on creating a more positive identity does not "blame" nurses for their oppression, but rather acknowledges the need to heal from past injury. The development of a more positive professional identity empowers individual nurses to join together to change a system that devalues them.

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Key words: empowerment; nursing identity; oppression

IMAGE GALLERY

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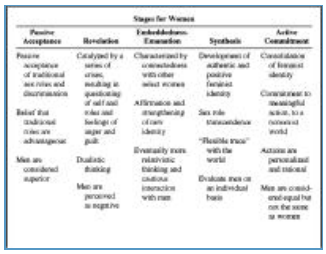

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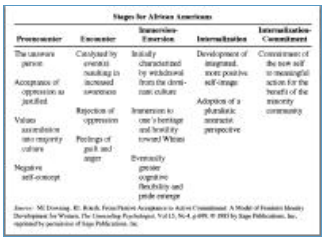

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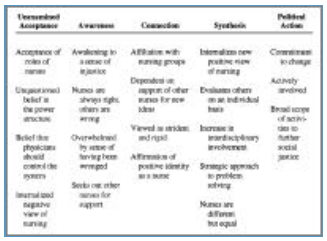

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