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UNDERSTANDING PUBLIC HEALTH PROFESSIONAL SOCIALIZATION AND PROFESSIONAL IDENTITY FORMATION EXPERIENCES

by

Jennifer Freiheit

A Dissertation Submitted in

Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy

in Urban Education

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December 2017

ABSTRACT

UNDERSTANDING PUBLIC HEALTH PROFESSIONAL SOCIALIZATION AND PROFESSIONAL IDENTITY FORMATION EXPERIENCES

by

Jennifer Freiheit

The University of Wisconsin-Milwaukee, 2017
Under the Supervision of Professor Barbara Daley

Public health is in unstable times with funding decreasing, an exodus of retirees, and a paradigm shift with emergency preparedness and response critically changing the identity of the profession. Public health is at a grave trigger point where if something is not done, the entire field may be in jeopardy of caving in to consolidations, poor succession planning, and a field that cannot work toward the health of the public if they themselves are not operating well. It is commonly accepted that orientation practices exist in public health agencies, but the orientations that currently exist lack transfer to full socialization into the practice insofar as employees lack the learning needed to build their professional identity. Better socialization can assist in developing leaders and retention in the field. It is incumbent upon health officers and other public health managers, the current public health leadership, to consider implementation of a variety of socialization efforts that include all of the above-mentioned components in practice to retain their workforce. With facilitated learning, retention and job satisfaction increases alongside the creation of greater identity building within the future public health workforce. With increased retention, more educated staff are able to help the communities that so desperately rely on the services that public health provides.

Little is empirically known about the professional socialization process and professional identity formation within the profession of public health. This study phenomenologically examined the professional socialization experience of eighteen local governmental urban and suburban public health employees, how organizational context played a role in their onboarding and induction, and how their professional identity formed as a result of the socialization and contextual experiences. Three major themes emerged. The first theme showed how public health professional socialization efforts are piecemeal at best, forcing new employees to new levels of resourcefulness. The second theme showed that new public health employees often experience programmatic and hierarchical isolation during an overwhelming orientation period and beyond, given a lack of support systems, silos, and lack of training on the bigger picture of public health. Both of these circumstances, when combined, result in the third theme - loose ties to the public health profession for employees between one and seven years of employment, feeling only a lukewarm insider status and their tenuous public health professional identity blowing in the breezeway. More importantly, poorly socialized public health newcomers may likely become someone else's first boss in just a matter of years, thus perpetuating the cycle and defying a change in organizational culture.

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This dissertation and my entire doctoral career is dedicated to

Aidee and Dad

TABLE OF CONTENTS

Abstract ii
List of Figures x
List of Tables xi
Acknowledgements xii
Chapter 1 1
Pertinent History of Public Health 1
In the Midst of a Shifting Paradigm 4
Purpose 9
Problem Statement 10
Research Questions 11
Need for Study 11
Significance of the Study 16
Operational Definitions 17
Public Health 17
Professional Socialization 17
Professional Identity 18
Organizational Context 18
Summary 18
Chapter 2: Literature Review 20
Literature Review Methodology and Inclusion Criteria 25
Professional Socialization 27
Definitions 27
Research Trends 28
Stages 28
Tactics and Content 33
Support 37
Agency 38
Outcomes 39
Learning Opportunities 40
Conclusion 42
Professional Identity 43

Definition ... 43
Later Development ... 45
Integrating Personal Values ... 47
Research Trends ... 48
Identity Threats ... 50
Circumventing Threats ... 53
Conclusion ... 55
Organizational Context ... 57
Definition ... 57
Specialist Versus Generalist ... 59
Organizational Concepts ... 60
Conclusion ... 62
Filling the Gap ... 63
Key Study ... 65
Conclusion ... 67
Chapter 3: Methodology ... 69
Philosophical Framework ... 69
Logic and Rationale for Choosing Qualitative Methods ... 69
Research Questions ... 70
Design Considerations: Specific Qualitative Approach ... 70
Sampling Strategy: Site/Participant Selection Description and Rationale ... 72
Entry, Rapport Building, Reciprocity, Possible Ethical Issues ... 74
Data Collection ... 75
Change of Method ... 77
Data Analysis ... 78
Quality Control ... 80
Prolonged Engagement ... 80
Clarifying Research Bias ... 80
Rich Thick Description ... 81
Positionality ... 81
Chapter 4: Findings ... 83
A Picture of the New Public Health Employee Emerges ... 83
Contextual Description of the Agencies ... 88

Description of the Participants 89
Thematic Extractions 92
Theme 1: Piecemeal Socialization 93
Overwhelming first months 93
Pace: All or nothing 93
Thrown in—figure it out 94
Length too short 96
Forced resourcefulness 97
Lack of academic preparation 100
Theme 2: Programmatic and Hierarchical Isolation 103
Lack of support systems 103
Boss as "mentor" 103
Deficient leadership 105
Importance of peers 106
Networking opportunities 109
Broader image missing 110
Strategic Plans 111
Political and Financial 113
Silos 115
Cross-training desired 117
Theme 3: Tenuous Professional Identity 119
False prior expectation = later satisfaction 119
Insider or outsider status 121
Feelings of impostership 124
Professional memberships lacking 126
Conclusion 127
Chapter 5: Discussion, Implications, and Conclusion 128
Research Question 1 129
Continuum Correlations 130
Correcting the Piecemeal Efforts 132
Research Question 2 133
Specialist or Generalist 133

Support Systems ... 135
Bigger Picture ... 137
Other Contextual Concepts ... 138
Research Question 3 ... 139
Identity Outcomes from Lacking Socialization ... 141
A Field in Flux ... 143
Multi-dimensional Identity ... 145
Commitment ... 146
Limitations ... 147
Implications for Education ... 149
Implications for Public Health Practice and Workforce Development ... 150
Implications for Future Research ... 152
Recommendations for Action ... 154
Supervisors ... 154
Professional Memberships ... 154
Statewide Orientation ... 155
Increase Community Involvement and Other Tactics ... 156
Researcher's Reflections ... 161
Conclusion ... 162
References ... 164
Appendix A: Annotated Bibliography Example ... 180
Appendix B: Empirical Sources ... 181
Appendix C: UWM Consent to Participate in Research ... 198
Appendix D: Individual Interview Protocol ... 203
Curriculum Vitae ... 209

LIST OF FIGURES

Figure 2.1: Socialization Tactics and Their Hypothesized Effects 35
Figure 2.2: Progression of Socialization Aspect of Workforce Development 62
Figure 5.1: Missing Socialization Leaves Tenuous Professional Identity in the Breezeway 128

LIST OF TABLES

Table 4.1: Overview of Participants 91

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Chapter 1

The field of public health is undergoing many changes that cause those within the profession to uneasily anticipate radical shifts ahead. Several past paradigmatic shifts have left the current workforce re-evaluating its past, current, and future professional identity. Leaders within the public health field can acknowledge the role that professional socialization efforts play in advancing professional identity within the organizational context; from recruitment and retention to job satisfaction. Professional socialization, a part of workforce development, is the process whereby new employees gain the values, skills, and knowledge upon career entry in order to become a successful employee. Cohen's (1981) socialization definition includes four goals: "learn the technology of the profession—the facts, skills, and theory; learn to internalize the professional culture; find a personally and professionally acceptable version of the role; and integrate this professional role into all the other life roles" (p. 15).

This research examined "advanced beginners" with at least one year of experience to "competent" local public health employees with 3-7 years' experience (Benner, 1984, 2001; Dreyfus & Dreyfus, 1980), to gain insight on the processes of professional identity formation and professional socialization efforts.

Pertinent History of Public Health

The public health community comprises a wide array of workforce members within various levels of government, from federal, state, and local government-run health departments and clinics to academia and not-for-profit agencies. Governmental public health employees (the largest group of public health workers) include many functional domains or segments: nurses (one of the largest cohorts of workers), health

officers, environmental health/sanitarians, health educators, clerks, as well as a host of business and finance-related employees at all levels and positions within their organizations. These employees are housed within a political system funded by both grants and state and local tax levies.

Federal public health agencies are many, including the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA). Each state, including the District of Columbia, maintains a state public health agency. State public health agencies work in tandem with local public health agencies. In one state, for example, state law mandates that every municipality must be serviced by a locally run governmental public health agency responsible for protecting the health of its citizens, (Wisconsin Gen. Laws, 1993). Ninety-six percent of states have local public agencies that operate in either a centralized, decentralized, or hybrid manner (Salinsky, 2010) with their state health department. Public health agencies are given broad and swift “policing” powers that reason that, “The public health cannot wait upon the slow processes of legislative body, or the leisurely deliberation of a court” (State ex rel. Nowotny v. City of Milwaukee et al., 1909). *Every citizen* is covered under these legal mandates regardless of race, age, income, or origin of citizenship.

The field of public health has “undergone radical change” (Brown & Duncan, 2002, p. 362) since its initial direction and focus on sanitation and vaccination in the 19th and early 20th centuries. Since the 1970s, public health’s focus has pivoted from a medical model (where public health practitioners took care of people ill with disease) towards a more “’social model of health’” (Brown & Duncan, 2002, p. 362) where public health practitioners concern themselves with the status of the public’s health *prior* to the

onset of illness; with intentions directed toward the prevention of widespread disease (both acute and chronic), increasing well-being, and decreasing disparities. This was a philosophical shift within the public health field towards a *health promotion* and *disease prevention* field instead of a *cure-based* field: curing illnesses lies on the shoulders of medical professions and not as much in public health. Where the two fields often overlapped in the early 20th century, now they are each separate entities with disparate services and functions (Fairchild, Rosner, Colgrove, Bayer, & Fried, 2010). Public health has a desire to alter behaviors *prior* to illnesses arising as well as stopping the spread of communicable diseases and creating the conditions in which people can be healthy (Institute of Medicine, 1988). The medical field is largely concerned about the treatment of illness and disease *after* it occurs. Public health is largely concerned with communities and not solely on individual health.

Then 9/11 occurred along with an ensuing anthrax attack, and suddenly those in the public health workforce found that their paradigm was changing once again. Since 9/11, Federal funding distributed to state and local public health departments dictated that public health is now considered a first responder, alongside police and fire. The new funding streams have been an effort to prepare the public health workforce for handling emergencies. This was determined because public health officials are the most knowledgeable and first in command for bioterrorism events, as well as naturally occurring diseases. This dramatic, new paradigm for public health, and its funding, brought an influx of new professionals to an aging public health workforce. A national average of 65.4% full time equivalent (FTE) workforce members received partial or full salary funding from these grants at the local public health agency level and a mean of

42 positions at each state health department level were created (Beitsch, Kodolikar, et al., 2006). This defining moment in the history of our country seemed to separate the public health workforce into two generations: the pre-9/11 workforce and the post-9/11 workforce. The pre-9/11 workforce, with the new onslaught of federal dollars and grant requirements, had to endure a huge paradigm shift from the way they were educated and the way they had been working in the field of public health for years and even decades. The post-9/11 workforce came in with fresh perspectives and ideas about how public health should now be viewed and operating. Both had effective ways of operating, and both needed to see ways of operating differently.

In the Midst of a Shifting Paradigm

Since the unprecedented occurrence of federal funding for public health emergency preparedness, as noted in the Alliance for Health Reform's report titled, *Bioterrorism and Public Health Funding: Current Threats and Proposed Responses*, jumped from $500 million in 2001 (before 9/11) to $2.9 billion in 2002 (as cited in McHugh, Staiti, & Felland, 2004), a new set of programs, with new goals and objectives, shifted the day-to-day operations of local public health agencies. Pre-9/11, an average public health worker's day might include a few restaurant inspections, providing inoculations at their vaccination clinic, meetings and planning for upcoming wellness events and activities such as hosting a 5k walk/run or an upcoming speaker, and/or working with schools to determine the cause of an outbreak which forced large numbers of students, faculty, and staff absenteeism.

In the post-9/11 world, these same workers had to continue all of their aforementioned responsibilities, but now had the added responsibility of being first

responders; leading organizational preparedness efforts for terrorism events such as a dirty bomb; becoming certified in the Incident Command System, forcing unprecedented collaborations with their local police and fire departments; and more intensive engagement and participation in drill based exercises and analyses in order to prepare for large scale based crises and emergencies. In addition to this shift, health departments are more recently looking at health inequity issues and how health is greatly determined by social and economic factors more than ever. This presents yet another challenge to the current public health workforce because addressing the social determinants of health and trying to change policy are new skills that many public health professionals were not trained in or even exposed to until arriving on the job.

Due to this workload increase (and funding), some of the older programs fell by the wayside. Some health departments decided to, or were forced to, discontinue programs, such as personal healthcare appointments (Gursky, 2004). This might include school nursing clinics or head lice checks, for example. At least one wellness service or program, such as maternal and child health (MCH) programs and immunizations, were decreased or eliminated by 57% of all local public health departments nationally in 2011 and 48% in 2012 showing broad programmatic cuts year after year (National Association of County and City Health Officials, 2013). In the year ending June 2009, 50% of local health departments cut at least one public health program, and 28% cut three or more programs (National Association of County and City Health Officials, 2010). These former programmatic staff were sometimes transferred to handle public health emergency preparedness, or new staff were hired to carry out

emergency preparedness grant objectives, both somewhat delineated from the former public health staff.

The health care field, along with many other entities, is in a state of flux, with funding cuts and restructuring that leaves an environment of uncertainty. The Patient Protection & Affordable Care Act (ACA) uncertainty also presents a new challenge for the public health field. With physicians and health care systems now incentivized to provide prevention services, the role of public health is further blurred (Gass & Bezold, 2013). The American Public Health Association states:

> A main tenet of the Affordable Care Act (ACA), the health care reform law signed in March 2010, is to transform our “sick care” system into one that focuses on prevention and health promotion. The success of this transformation largely rests on a sufficiently sized, adequately trained workforce that can provide the community and clinical preventive health services that are needed to promote and protect the nation’s health. (Morrissey, 2011, p. 3).

It is yet unclear whether the sufficient and adequately trained workforce, mentioned above, will stem from physicians and others in the health care system or from a collaborative working relationship between the medical sphere and public health field. Another redefinition of public health’s role may be around the corner, but has yet to be seen or determined, thus creating uncertainty in public health leadership planning and among public health staff worried about their positions.

The numbers of public health employees in the workforce are in a downward spiral as well. Across the nation, the public health workforce is aging rapidly. More than 100,000 public health workforce members, out of approximately 450,000, were eligible

to retire by 2012 (Association of Schools of Public Health, 2008). Public health workers were estimated to be 220 per 100,000 population in 1980 yet only numbered 158 per 100,000 in 2000, a 28% decrease in public health workforce resulting from the combination of 2 factors: a 10% decrease in public health workforce and population increases across the USA of nearly 25% during that same time period (Merrill, Btoush, Gupta, & Gebbie, 2003; U. S. Department of Health and Human Services, 2000). Eligible retirements of state health agency employees increased 7% in the four years leading up to 2016 (Association of State and Territorial Health Officials, 2014, p.29). Nationally, local governmental public health jobs lost totaled 29,000 between 2008 and 2010, or 19% of the total national 2008 workforce, due to the economic downturn with layoffs and attrition (National Association of County and City Health Officials, 2011). The Public Health Workforce Interests and Needs Survey (PH WINS) found that 40% of public health employees from the federal to the local level were either planning to retire by 2020 or were considering leaving their organization (Leider, Harper, Shon, Sellers, & Castrucci, 2016; Pourshaban, Basurto-Davila, & Shih, 2015). Eligible retirement numbers are not the only issue to jeopardize workforce development; funding has been in a continuous decline.

More recently, federal grant dollars and local budgets have been in continual decline (ASTHO, 2014; Gebbie & Turnock, 2006; Levi, 2007; Morrissey, 2011; NACCHO, 2013). Between 2008 and 2010, two-thirds of states “cut funding for public health . . . and 15 of these states cut funding for a second year in a row” (Trust For America’s Health, 2011, p. 12). Between January 2009 and January 2010, 53 percent of local health departments experienced core funding cuts, and 47 percent anticipate more

cuts by January 2011 (NACCHO, 2010). These cuts to general revenue and tax levies were mitigated for a short period by the large emergency preparedness grant dispersal post-9/11, but now those grants are declining as well.

Due to low pay and lack of work incentives, more of the public health workforce is diminishing, and recruitment difficulties are prevalent (C. A. G. Crawford et al., 2009). Governmental public health salaries and benefits are dramatically lower than in other fields (McHugh et al., 2004; Morrissey, 2011), one of the prime factors of public health workforce diminishment. Another issue includes "administrative and bureaucratic obstacles":

> State and local agencies face some of the most serious recruitment and retention problems, including slow governmental hiring; rigid civil service systems; hiring freezes; governmental budget crises; and the lack of career ladders, competitive salary structures, and other forms of recognition that value workers for their skill and performance (Gebbie & Turnock, 2006, p. 927; U. S. Department of Health and Human Services, 2005).

According to Draper, Hurley, and Lauer (2008), the "factors influencing the workforce shortage include inadequate funding, uncompetitive salaries and benefits, an exodus of retiring workers, insufficient supply of trained workers, and lack of enthusiasm for public health as a career choice" (p.1) including not being able to properly respond to crises and increased stress since 9/11. Related to the inadequate funding are budget constraints, given that less than 3% of the more than $3 trillion spent annually on U.S. health care goes to governmental public health programs (Leider, Resnick, et al., 2016), budgeting constraints represent the "single biggest barrier" to hiring public health

workers (HRSA, 2005, p. 2). Even with these cuts and low funding, “the largest percentage of the public health budget is invested in its workforce” (Beitsch, Brooks, Menachemi, & Libby, 2006, p. 920).

These statistics show a grim reality. From the unprecedented increase and later decline in federal grants for emergency preparedness, to changing programs and workloads alongside the uncertain future of the Patient Protection & Affordable Care Act (ACA), the importance of needing to focus on public health workforce development is shown, in addition to recruitment and retention, amid massive retirements, loss of workforce, low pay and incentives, and recruitment difficulties.

Purpose

The purpose of this research was to identify and understand the factors contributing to the professional socialization processes in public health and how that process creates a professional identify for a public health worker. After working for 15 years within the public health field (1 year in state government, 8 years in local government, and 7 years consulting with local public health), I saw many bright, talented future leaders come and go and wondered why these employees were not being retained within the field. In my work experience in public health, I often considered leaving the field due to a lack of trainings and mentoring. So, I wondered if the reason why so many were leaving was because new public health employees were not being socialized into the field through training, orientation, and support systems with incentives such as mentorship and induction programs like in the medical and teaching professions. My dissertation research therefore centers around fairly new public health employees (those that have worked in the field for 1 to 7 years) and the support

systems they do or do not have available to them. My hope is that my research helps to inform the public health field in making changes in how the field supports and retains new public health employees.

When my research began, I found a dearth of empirical literature on public health professional identity and professional socialization efforts. Many other fields had covered these topics extensively. This was a gap not to be ignored. This research identified and analyzed factors contributing to professional identity and recommends ideas and solutions that can help improve workforce development within the field.

Problem Statement

Current research makes a leap from academic training in public health to career succession planning within the field and overlooks the vital role of new employee entry into the field. Many reports call for more detailed workforce development but rarely mention the need to socialize new employees. None are concerned with building new employees' public health professional identity. Professional socialization may exist both formally and informally; however, very little has been scientifically studied about how these efforts are currently structured and how they impact formation of a professional identity for public health as part of future workforce development. Professional socialization processes serve a vital role in assuring that employees are not only competent and prepared to do their jobs, but that employees will remain in the field with higher levels of job satisfaction and performance having been thoroughly trained and socialized upon career entry.

Professional socialization and professional identity serve a vital role in any profession, but both need to be explored in the field of public health. This is important,

because vast numbers of public health employees are leaving the field and retiring, thus threatening the health of the public. Several prominent public health leaders are concerned that there is not enough succession planning in place or succession planning with incomplete structured practices (Darnell & Campbell, 2015; Gaufin, Kennedy, & Struthers, 2010; Leider, Harper, Shon, et al., 2016; Sellers et al., 2015; Wiesman, Babich, Umble, & Baker, 2016), leaving the transfer of history and knowledge in jeopardy, including the loss of mentors (Draper, Hurley, & Lauer, 2008). Organizational context can influence the professional socialization process, which in turn can aid in the formation of professional identity. Public health leaders need to better understand how these factors are perceived in order to impact and retain public health professionals.

Research Questions

Due to the above concerns, my research questions are:

- How do urban public health employees experience the professional socialization process within their profession?
- How do the organizational contexts elicit or diminish professional socialization processes in the field of public health?
- What influence does the professional socialization process have on the formation of a public health professional identity?

Need for the Study

This research identified factors and issues within the professional socialization processes as well as professional identity development within the public health field; such gaps may be affecting recruitment and retention of new talent in the wake of massive retirement levels, funding cuts, and paradigm shifts. Other professional fields point to the importance of having strong, well-planned induction programs, professional socialization mechanisms, and support systems for those entering the field in order to

form a professional identity (Kammeyer-Mueller, Wanberg, Rubenstein, & Song, 2013; Klein & Weaver, 2000; Wood, 2015). Training, mentorship, and increased pay are all needed to recruit and retain bright talent to the public health field. Public health is at a grave trigger point where if something is not done, the entire field may be in jeopardy of falling prey to consolidations (Gass & Bezold, 2013) and lackluster leadership (Draper et al., 2008; Gursky, 2004; N. Lurie, Wasserman, & Nelson, 2006). It is a field that cannot work on behalf of the health of the public if the system is not operating well. This workforce crisis will continue to plague local health departments in their recruiting, training, and retention cycle. In turn, meeting their community's needs will be affected (Draper et al., 2008).

Several sources point to the need for research and processes on the betterment of the public health workforce (Beitsch, Brooks, et al., 2006; Hayden, 1995; Kaufman et al., 2014) in addition to the groundbreaking and still relevant Institute of Medicine (IOM) report, *The Future of Public Health* (1988), which recommends that "education programs for public health professionals should be informed by comprehensive and current data on public health personnel and their employment opportunities and needs" (p. 17), citing that "resources for particular needs to fulfill the mission of public health, such as leadership training, are being cut back" (p. 80). This resonates even more after 9/11, with public health now more than ever in a leadership seat within municipalities for protecting citizens during emergencies. With regard to leadership and retention, it would behoove public health leaders to have long-term continuity of employment and longevity of institutional memory to pass on knowledge to a new workforce, equipping them with the ability to display political acumen in embracing ever-evolving governmental

challenges. The Committee on Assuring the Health of the Public in the 21st Century found that there has been "great difficulty in recruiting, developing, and retaining the leaders so vital to the job" (Institute of Medicine of the National Academies, 2003, p. 121).

The National Association of City and County Health Officials agrees, finding workforce development issues are one of state and local public health's biggest challenges, second only to funding (Hajat, Brown, & Fraser, 2001). The issue continues through time because of the constant and "significant changes in the types of services [local public health departments] provide and the roles they are expected to fulfill, education and training are needed to prepare new and current local public health staff to meet these changing expectations" (Gebbie, Rosenstock, & Hernandez, 2003, p. 146). The post-9/11 environment for public health workers heightens this due to the dramatic paradigm shift in first responder status. These same issues get brought up in report after report, through the years, always attempting to detail any improvement, but reiterating the need for continued improvement on the issue of preparing a new public health workforce in times of constant evolution of roles and expectations (Beck & Boulton, 2012). Studying organizational context, professional socialization processes, and the formation of a public health professional identity can lead to a more comprehensive understanding of public health future workforce development needs, bringing a fresh perspective to such concerns.

Another identified logic model (Cioffi et al., 2004) points to the need to determine the best indicators for workforce performance within public health and what organizational variables lead to the competency development of public health

employees. Local public health agencies, like any other profession, want to have the best workforce. Current reports all parrot that research is needed in workforce development and to empirically measure various workforce policies. Knowing which strategies will successfully assist the health departments with their attracting, training, and retention efforts, beyond the already studied succession planning efforts, would be helpful (C. A. G. Crawford et al., 2009).

In an effort to identify which strategies C. A. G. Crawford et al. (2009) seek to understand, Draper et al. (2008) note that a "remarkably small number of public health workers have received a basic introduction to public health beyond their immediate job functions" (p.3). The Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances Disease Registry (ATSDR) estimate that 80 percent of the current workforce lacks formal training in public health in their 2001 draft, *A Global and National Implementation Plan for Public Health Workforce Development* (as cited in IOM, 2003). Amodeo (2003) further questions the "appropriateness of initial training" (p. 500) and training deficits within the field, and investigates the premise that the current workforce has minimal to no training in public health "core competencies of traditional public health practice, much less the skill set necessary to work with communities" (p. 502). Governmental public health agencies "are wrestling with an overall lack of formal orientation to public health among workers, and in some cases, deficits in core public health skills" (Draper et al., 2008, p. 3) such as epidemiology and surveillance. This deficit of formal public health education "has necessitated a focus on in-place training and, more recently, distance learning" (Leider, Harper, Bharthapudi, & Castrucci, 2015,

p. S57) even though the overall educational attainment among public health employees is relatively high.

Public health leaders call for more research in the public health workforce agenda (Cioffi et al, 2004; Tilson & Gebbie, 2004). At the First Annual Public Health Workforce Development Meeting in November 2000 (Lichtveld et al., 2001; Tilson & Gebbie, 2004), a host of potential research questions were developed, a few of which relate to this proposal:

- What do front line managers and workers think they need to know to perform effectively?
- What methods are most effective in building competency (more than training)?
- What is the educational profile of public health workforce at the time of entry into practice?

If the profession is attempting to redefine itself, how can its leader's best go about educating, recruiting, and retaining its workforce? Does the understanding of professional identity and professional socialization assist in the education, recruiting, and retaining processes? Tilson and Gebbie (2001) recognize socialization's opportunity to positively effect change with various groups of public health workers whether through orientations, mentorship, networking, or other modalities.

The Public Health Service of the U.S. Department of Health and Human Services (1997) further details how "support staff (e.g., receptionists, clinic assistants, laboratory assistants) often are not effectively oriented to the public health goals of the organization and are limited in the contributions they are able to make to the overall

effort” (p. 5). More knowledge is needed for understanding how professional socialization and professional identity aid the public health workforce even beyond recruitment and retention.

Significance of the Study

The significance and contribution of this research to the practice of public health would be to aid in current public health leaders’ understanding of how professional socialization practices contribute to future workforce development and retention while building individual professional identity. An ancillary outcome might be that the research has implications for other career fields as well.

Current public health leaders that might find this research valuable and applicable may be found at the local, state, and national levels. Public health leaders in non-profit, policy, and advocacy organizations, such as the National Association of County and City Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the American Public Health Association (APHA), and the public health agencies of the U.S. Department of Health and Human Services (HHS) may use this research. Additionally, the Robert Wood Johnson Foundation (RWJF) and RAND Corporation might use the results to support some of their research into the field of public health.

This study is significant for the field of public health because little is known about the topic, yet many funding and policy decisions are being made surrounding the presence and quality of the public health workforce. There is a great need to understand professional identity for the future of public health and better application of tax dollars applied to public health, because there exists a “general lack of political support for

public health [as it] is just not a priority for our legislature . . . competes with fire and police for funding" (Draper et al., 2008, p. 4) and "being asked to do more with fewer resources, assuming larger caseloads, and trying to manage demanding federal grant requirements" (Draper et al., 2008, p. 5). These funding issues "often preclude offering [orientations] with the frequency needed for them to be timely for all new hires" (Klein & Weaver, 2000, p. 62).

Operational Definitions

Public Health

A foundational framework for the field of public health can be defined via the 10 Essential Public Health Services, which include assuring a competent public and personal health care workforce and evaluating effectiveness, accessibility, and quality of personal and population-based health services. In 1988, the Institute of Medicine (IOM) defined public health as "organized community efforts aimed at the prevention of disease and promotion of health. It links many disciplines and rests upon the scientific core of epidemiology" (IOM, 1988, p. 41). "Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy" (IOM, 1988, p. 1). The focus of this research was on governmental public health, specifically local public health agencies within a medium-sized urban area, whose functions have traditionally included a wide variety of services from school nursing and vaccinations to environmental assessments and restaurant inspections.

Professional socialization

For purposes of this research, the following definition of professional socialization was used. Socialization, a lifelong learning process, is often described

using variations on Weidman, Twale, and Stein’s (2001) definition whereby “individuals gain the knowledge, skills, and values necessary for successful entry into a professional career requiring an advanced level of specialized knowledge and skills” (p. iii). From here forth, professional socialization will be simplified to just socialization for purposes of this paper, whether that socialization occurs during education with student learners or equivalently to new employees in an organization.

Professional identity

Professional identity has been referred to as career, occupational, or even vocational identity (Holland, Johnston, & Asama, 1993; Skorikov & Vondracek, 2011) and becomes a portion of a person’s overall identity and sense of self (Johnson, Cowin, Wilson, & Young, 2012). Professional identity includes one’s professional self-concept based on attributes, beliefs, values, motives, and experiences (Ibarra, 1999; Schein, 1978).

Organizational context

Utilizing in part the seminal work of Ein-Dor and Segev (1978), the organizational contexts in this research include: size of the organization (measured by workforce), psychological climate (attitudes, expectations, and perceptions toward the department and work) including cohesiveness, collaborations, and leadership, and generalist or specialist role of each person interviewed.

Summary

The public health profession is one that is not easily defined, nor is it finite. It is a broad, nebulous field that draws upon people from many backgrounds and levels of training and education. It is a field that has evolved over the past century and promises

to evolve and change focus yet again in the coming decade. As a result, there is a need to establish parameters on professional socialization and professional identity due to the major shifts occurring within the field that are impacting the workforce both directly and indirectly.

The next chapter, Chapter 2, will examine literature from well-researched professions, such as nursing, medicine, and teaching, to explore the concepts of professional identity and socialization due to their close collaboration and similar roles as public health. Methodology including philosophical framework, data analysis, and quality control will be detailed in Chapter 3. Findings and three thematic extractions will be presented in Chapter 4, and Chapter 5 will conclude with discussion, implications, and recommended actions for how these themes can impact the field of public health.

Chapter 2: Literature Review

The public health climate is currently one of instability. Amidst a tumultuous political environment, the healthcare landscape is changing. Public health, as part of a governmental structure, has been slow to sway with changes to this landscape and remain relevant, maintaining critical mass of its workforce while shouldering the numerous responsibilities including protecting the public from communicable diseases to potential terrorist attacks. Public health field retirements are looming large in what has been coined as a mass exodus from public health (Draper et al., 2008; Fairchild et al., 2010). Compounding the retirement exodus is a steady decline from both grants and state annual funding as well as local tax levies. These drivers and pressures from both within and outside the field are culminating in the creation of an identity crisis.

After 9/11 and the subsequent anthrax scares, federal agencies such as the Centers for Disease Control and Prevention (CDC) granted large sums of money to state and municipal public health departments in an effort to prepare the public health workforce for natural disasters and bioterrorism emergencies (Beitsch, Brooks, et al., 2006). This shift in the locus of responsibility for public health workers brought an influx of new talent to the steadily aging public health workforce. But after more than a decade of funding declines for emergency preparedness, the younger, more diverse, and better educated public health professionals were drawn to leave the field of public health rather than stay within the public health arena (Leider, Harper, Shon, et al., 2016). Counter-balancing factors that were found to significantly and positively correlate to governmental employees deciding to remain with their current employer, were a commitment to public service and identifying with the organization’s mission (Yeager,

Wisniewski, Amos, & Bialek, 2016). Nationally it is projected that the public health workforce will need to increase from an approximate total of 450,000 in 2000 to 739,000 by 2020 (Rosenstock et al., 2008) so as to manage the needs of an ever-growing population and return to the ratio of 220 public health workers per 100,000 population that existed in 1980. The large projected retirement numbers create an additional significant challenge to reaching this ratio.

Such retirement exodus, change in locus of responsibility, and funding declines are all part of the pressures driving this workforce-based identity crisis. Public health workers may leave their position for external factors such as funding cuts, restructuring, retirement, or spouse relocation. Beyond these external events, internal drivers, such as lack of job satisfaction, poor leadership, co-worker issues, and lack of training and workforce development also play a major role in the creation of public health workforce exodus. It is these internal factors that management and administrators within the public health field are most amenable to remedy if they, themselves, had appropriate socialization, leadership training, mentoring, etc. Harper, Castrucci, Bharthapudi, and Sellers (2015) posit that "public health leaders aiming to improve levels of job satisfaction should focus on workforce development and training efforts as well as adequate supervisory support, especially for new hires and nonsupervisors" (p. S46). Therefore, it is these internal issues which lend themselves to greater solution building, especially if public health leaders employ successful tactics from other fields.

One suggested solution to lack of a professional identity is to ensure proper socialization processes. Having new employees socialized upon entering the field can readily be enhanced and utilized. This reinforces the need for extended socialization

and professional identity-building, so that new employees will stay in the field long enough to become the leaders that in turn will socialize more new employees. This would aid in creating a critical workforce mass for present and future public health departments.

Support systems, also known as “agents,” for any new employees entering the field (Bauer, Morrison, & Callister, 1998) are a necessity and fit into the larger context of professional socialization efforts. Agencies that seek to understand employees, provide better leadership, and provide continuous workforce development opportunities are sure to reap the benefits of better workforce retention while also investigating the expansion of job pay and benefits for their workers, both of which are reassuring but insufficient to retaining employees. Yeager, Wisniewski, Amos, and Bialek (2016) found that “job security and competitive benefits were significantly and positively associated with governmental employees’ decisions to take positions with their current organizations” (p. 561). Additionally, public health departments can provide better orientations, induction periods, socialization, and mentoring, all of which can lead to better recruitment, retention, and job satisfaction and the creation of greater identity building within the future public health workforce (Harper, Castrucci, Bharthapudi, & Sellers, 2015; Leider, Harper, Shon, et al., 2016; Liss-Levinson, Bharthapudi, Leider, & Sellers, 2015). There is a need to understand how the profession of public health assists in forming an identity for new employees leading to seasoned public health workers with a strong professional identity throughout the public health workforce continuum.

To address this issue, this research borrowed from other well-researched professions, such as nursing, medicine, and teaching, to explore the concepts of

professional identity and socialization due to their close collaboration and similar roles as public health. Public health has clinical components, hence the similarity to socialization in nursing and medicine. With regard to the education profession providing comparison, both teachers and public health workers work autonomously while providing education to large audiences and both often under government pay structures. These fields have successfully applied socialization and provide best practices and evidence that can be applied to the public health workforce more so than other fields such as the military or private businesses.

Examination of the factors contributing to this workforce-based public health identity crisis are the focus of my scholarly research. Also from that examination, my research prepares practical applications for public health agencies with regards to professional identity building and socialization programs, which can be implemented on an immediate and timely basis. Given this focus, several concepts were reviewed but only included if answering the three main research questions.

Current scientific literature tells us little about the factors that lead to public health retention. This lack of understanding of employee retention may explain why only 40% of local public health agencies have either formal or informal succession plans in place and why only 62% are very concerned about retaining staff (Darnell & Campbell, 2015). There is even less known about the professional identity experiences of new public health employees. The lack of public health workforce socialization is therefore one of the greatest contributing factors to poor or non-existent professional identity within the changing landscape of the field.

This research begins to fill a gap that has not been explored; one that can link to other well researched areas within the public health field such as workforce development and succession planning. Current research makes a leap from academic public health training to career succession planning within the field and overlooks the vital role that socialization plays with regard to recruitment and retention. Therefore the public health field needs to assist its new employees to remain in the field with socialization programs which benefit the creation and integration of a true professional identity into one's persona. Without such a pathway, the gap between current workforce development and succession planning will remain, and the workforce identity crisis will not abate. Much more research into public health socialization and professional identity factors needs to be done, and therefore, it is anticipated that my research will serve as contribution not only to the scholarly expansion with this field, but also to the practical applications able to be implemented by public health departments henceforth.

In order to ground this research, the following literature review examines the concepts of professional socialization, professional identity, and organizational context. These three concepts are fundamental to the research questions of this study.

Literature Review Methodology and Inclusion Criteria

Due to the lack of empirical studies surrounding public health socialization and professional identity, this literature review includes empirical studies drawn mainly from the public health related disciplines of nursing, medicine, and teaching. Students, as a sub-population from within these fields are also included, because they lend a perspective to the pre-preparatory phases around identity building and socialization. There are many anecdotal, opinion, policy, and review articles from peer-reviewed sources and books published after 1950, with relation to retention, role clarity, job satisfaction, turnover, leadership training, orientation, induction, onboarding, and mentorship, all contained in reference to the main topic of public health socialization.

Most of the search for relevant literature occurred in Google Scholar with some searches in PubMed, the UWM library database, MEDLINE, and PsychIFO. The main search terms used were “public health” and “professional identity,” “socialization,” and “organizational context.” Other keywords used to locate the search were “professional socialization,” “newcomer,” “new employees,” “novice,” “orientation,” and “induction,” each combined with the term “public health” in order to narrow the search. The search for unpublished studies (i.e., dissertations) was conducted using ProQuest. A search of governmental public health literature was undertaken using Google and Google Scholar. Public health organizational websites were also explored for additional relevant references including the American Public Health Association website, www.apha.org. Reference lists of retained articles were manually searched for identification of seminal research as well as with other related literature.

A few specific public health journals were searched for any related articles. These include: *Annual Review of Public Health, American Journal of Public Health, Human Resources for Health, BMC Public Health*, and the *Journal of Public Health Management and Practice* (the latter producing the most material). Any source that related to professional identity, socialization, and organizational context or any of the above keywords was entered into an Excel spreadsheet annotated bibliography. This database included the type of article, an annotated bibliography, the summary, keywords, and any included definitions or theories. This spreadsheet (Appendix A: Annotated Bibliography Example) helped to classify the documents, create summaries, identify constructs, and hypothesize about casual linkages as well as search for contrary findings and rival interpretations. Appendix B, Empirical Sources, shows the actual literature reviewed and utilized within this literature review which most closely relate to the answering of my selected research questions.

Using socialization and professional identity literature drawn from related professions, this review first examines the literature's value in replication and application to the public health field. Any inclusion herein was specifically selected due to its relatability to public health, thus answering this study's research questions. The literature stressed that lack of succession planning for the impending shortage of public health workers, makes it imperative that current public health administrators and policy developers incorporate effective and researched programs and tactics into the field of practice. This is important for the field of public health, in that this research analyzed the socialization tactics, psychosocial support, and philosophical beliefs of employees while comparing to components from other fields and their research. The order of literature

analyzed first focuses on literature from within the professional socialization area, then professional identity, and finally organizational context.

Professional Socialization

Definition

Socialization, as a lifelong learning process, is often described with regards to workforce and career development using variances on the Weidman et al. (2001) definition whereby “individuals gain the knowledge, skills, and values necessary for successful entry into a professional career requiring an advanced level of specialized knowledge and skills” (p. iii). Waugaman and Lohrer (2000) add a career commitment component, aptly emphasizing the “circumstances under which a person enters a profession tend to be predictive of how that person will view the profession for the rest of his or her life” (p. 47). Cohen’s (1981) socialization definition includes four goals: “learn the technology of the profession—the facts, skills, and theory; learn to internalize the professional culture; find a personally and professionally acceptable version of the role; and integrate this professional role into all the other life roles” (p. 15).

More simply stated, seminal definitions describe professional socialization as “the process by which an individual acquires the social knowledge and skills necessary to assume an organizational role” and refers to the “fashion in which an individual is taught and learns what behaviors and perspectives are customary and desirable within the work setting as well as what ones are not” (Van Maanen & Schein, 1979, pp. 211-212). Van Maanen and Schein (1979) interpret Shibutani’s (1962) early description of socialization as providing “the individual with an ordered view of the work life that runs ahead and guides experience, orders and shapes personal relationship in the work

setting, and provides the ground rules under which everyday conduct is to be managed" (p. 212)

Early on, Ritzer (1971 *[sic]*) took the definition one step further by defining certain attributes of socialization such as "community rather than self-interest, membership in professional associations, recognition by the public, and involvement in professional culture" (as cited in Hayden, 1995, p. 271). Others included autonomy, sense of calling to the field, and "a belief in service to the public" (Hall, 1968, p. 93). This calling to a field benefits both the public and the professional. A calling to public service is a key component to working in public health.

Research Trends

Socialization research has focused on stages of socialization; organizational tactics, such as *how* and *who* delivers socialization efforts; and the content, or *what* is included in socialization. Early socialization research focused on content and norms being delivered to a passive employee or student newcomer who would readily accept what was being taught (Clouder, 2003). Others early on, dove into the sense-making of new employees and the reciprocal proactive process of socialization (McKinney, Saxe, & Cobb, 1998; Schaubroeck, Peng, & Hannah, 2013). The following covers these historical trends in socialization research and concludes with the benefits and pitfalls of socialization before transitioning into professional identity.

Stages

Many studies, both theoretical and empirical, have focused on defining the dimensions of socialization. When socialization is viewed from a staged perspective, there are a few theories. Numerous arguments throughout the literature have been

made as to whether a person's socialization begins during their education and accounting for a person's pre-entry desires and expectations, (Merton, Reader, & Kendall, 1957; Porter, Lawler, & Hackman, 1975) or during their professional practice (Buchanan, 1974; Cervero, 1992).

Feldman (1976), in his study of new hospital employees, specified three stages of socialization: the "getting in" stage, Anticipatory Socialization, begins before arriving to the profession, and continues through Accommodation, where a newcomer is "broken in." The third of Feldman's stages, Role Management, occurs when a new employee settles in, and begins a career melding process with one's personal life. Weidman et al. (2001) similarly delineated the above stages into 4 categories of his own: Anticipatory, Formal, Informal, and Personal.

Schein's (1978) three-stage model looks at socialization from the individual's perspective as well as that of the organization. It includes a pre-entry recruitment stage and two post-entry stages, those of socialization and mutual acceptance. Schein emphasizes that the "perspective one learns during the socialization stage has important consequences for the future career . . . [influencing] future behavior in the organization" (p. 102). With this, he stresses how critical the first boss is to a new employee's future success, expressing the need to train managers to be able to socialize well. Other research also agrees around the importance of training supervisors and co-workers as to how to offer mentoring and support to new recruits (Kammeyer-Mueller et al., 2013; Ostroff & Kozlowski, 1992) for it is those with whom new employees interact on a daily basis that have the most influence on successful socialization (Levett-Jones & Lathlean, 2008). Schein (1978) also goes into a level of

operational detail with each of his three stages, where he identifies tasks and solutions for both the organization as well as its new employees that few others detail with such clarity. For example, Schein points out that new employees sometimes find themselves defining their own job description and sometimes must assist their supervisor in defining their position as well. Schein suggests to combat issues with job definition is to train supervisors in how to deal with new employees and to have supervisors provide feedback often to the new employees.

Van Maanen's (1975) staged socialization study of police recruits spans time periods in an employee's life from pre-career entry and selection to introduction, encounter, and metamorphosis. It is clear that those engaged in police work hold a strong professional identity, which in turn is demonstrated as contributory to an even stronger socialization process. Negative aspects of socialization that were sometimes avoided in other theories proved to be grounds for stronger acceptance within socialization for the police field (i.e., having "made it" through the tough parts of socialization, moving beyond a clear "rookie" status). Public health, unlike the police field (even though now considered a first responder in a post-9/11 era), does not have such a controlled socialization process. The diversity of roles and responsibilities within public health organizations may not allow for a formal initiation and initial acceptance period.

Buchanan's (1974) conceptualization examines socialization via three stages of development based on number of years the employee worked. For his definitional conceptualization, he studied large manufacturing and governmental agencies and the new employee's level of commitment, arriving at the following: Stage one includes the

first year of basic training and initiation where new employees experience a trifecta of organizational attributes: reality shock, role clarity, and cohesion with their peers. Stage two includes years two to four, where uncertainty and fear of failure occur. Loyalty and self-image are guides to success in this stage. Stage three concerns the fifth year of work and beyond when commitment to the organization is stronger and occupational maturity occurs. This research sought these outcomes in the participants that are between 1 and 7 years.

Professional socialization has also been parsed into three analytically distinct dimensions: education (imparting job knowledge), cognitive development of occupational orientations, and forming personal motivational relatedness to the occupation (Simpson, 1979). E. E. Lurie (1981), in contrast, breaks down socialization into two components: that which is acquired during pre-practice education, “the most important determinant of role content” (p. 46) and thus the primary determinant of socialization because without it, there would be no professional; and that which is received during employment, the “more powerful determinant” (p. 46), given the opportunities for employment afforded there. Because employees within the public health sector come from many paths, not all of which are academic, *role content* is not always obtained while in attendance at school. For many public health employees, *role content* must be obtained during entry to a career, thus contrary to E. E. Lurie’s defined types of socialization.

E. E. Lurie (1981) goes on to describe three “major sociological approaches to professional socialization” (p. 31) that are not mutually exclusive. One is the Mertonian school, which has stressed an indirect learning of attitudes, values, and behaviors

beyond direct academic learning and training, all of which are deemed to be primary determinants of socialization. Another sociological approach to socialization is the "Becker-Freidson school, which has stressed the determining effect of situational factors in the work setting" (p. 31)—a move away from the academic setting. The final approach, by Light (1980):

> views professional socialization as the result of an interactive process. The recipient actively seeks to be socialized, chooses a certain profession (and thereby certain central values), responds to other actors in the situation, and finally decides between the limited situational alternatives and the available professional role models on the basis of personal compatibility. (E. E. Lurie, 1981, p. 31)

Light sees this as a process of breaking down a person's identity in order to build up a new identity that includes a new profession.

While this research sought to learn about *professional* socialization, there is a wide body of research about *organizational* socialization that must be explained due to the possibility of participants detailing experiences of both during interviews. Wanous's (1992) socialization definition designates four outcome-based stages beginning with organizational entry (where one confronts and accepts the reality at the new workplace) before moving to stage two or that of achieving role clarity. Stage 3, according to Wanous, is an integrational stage where one adopts new values and is able to "find" themselves within the organizational context. Wanous's stage 4 focuses on positive organizational attributes such as when high satisfaction and commitment are achieved, thus leading one to success while ignoring the possible negative personal aspects of

one's job. But what Wanous does make clear is that socialization is a determinative process as to "how organizations change newcomers" (p. 234). His view comes exclusively from an organization's standpoint in assisting the newcomer to commit to the norms, values, and beliefs that the organization holds dear, and not about whether the employee gains any psychological gratification or benefits from the process.

Tactics and Content

With regard to organizational tactics, the *how* of socialization, seminalists Van Maanen and Schein (1979) identify six continuums of socialization that are a starting point for organizations to begin with and not meant to be all inclusive or necessary towards the development of a socialization process. The six dimensions include:

- *Collective* versus *Individual* socialization processes (i.e. medical students versus Ph.D. ABD students, differentiating newcomers being inducted similarly in a group or having a unique set of experiences individually);
- *Formal* versus *Informal* socialization processes (i.e. where formal processes include set goals and agendas and removing the new employee from the rest of the employees during the socialization process, instead of a more unstructured and informal approach);
- *Sequential* versus *Random* steps in the socialization processes (i.e. sequential having identifiable steps versus random ambiguous steps);
- *Fixed* versus *Variable* socialization processes (i.e. where the former has time frames over more flexible milestones of the latter);

- *Serial* versus *Disjunctive* socialization processes (i.e. role models providing feedback via a planned training as opposed to a disjunctive model that offers no role models); and
- *Investiture* versus *Divestiture* socialization processes (i.e. investiture welcoming diversity and personal experience and divestiture seeking conformity).

Jones (1986) takes the Van Maanen and Schein (1979) model one step further, showing that collective, formal, sequential, fixed, serial, and investiture tactics are in line with a more passive socialization process where a newcomer accepts whatever role is presented, (labeled by Jones as *institutionalized socialization)*. This type of socialization is likely to be seen "as functional for large and mechanistic organizations, given their proclivity toward reproducing the status quo and exerting greater control over newcomers' attitudes and behavior" (Ashforth, Saks, & Lee, 1998, p. 919). Such passive socialization processes assist in strengthening adjustment and conformity attributes within new employees while also extending Van Maanen and Schein's (1979) findings that such passivity produces less ambiguity, role conflict, and stress, and while contributing to greater job satisfaction. Ashforth and Saks (1996) counter, "conversely, at the opposite end of the socialization continuum, individual, informal, random, variable, disjunctive, and divestiture tactics encourage newcomers to question the status quo and develop their own approach to their roles" (p. 150). This is labeled as *individualized socialization*, noting that it "may occur more by default than by design" (Ashforth & Saks, 1996, p. 151) but produces more innovative role orientations (Jones, 1986). Each participant of this research study was evaluated for "fit" within the Van Maanen and Schein continuum of socialization.

Ashforth and Saks (1996) further the research of Jones (1986) and Van Maanen and Schein (1979) and concur with Jones (1986) with regard to outcomes of the various socialization tactics (Figure 2.1: Socialization Tactics and Their Hypothesized Effects). In Figure 2.1, Van Maanen & Schein's (1979) model is in the top box, and Jones' (1986) model is in the bottom box).

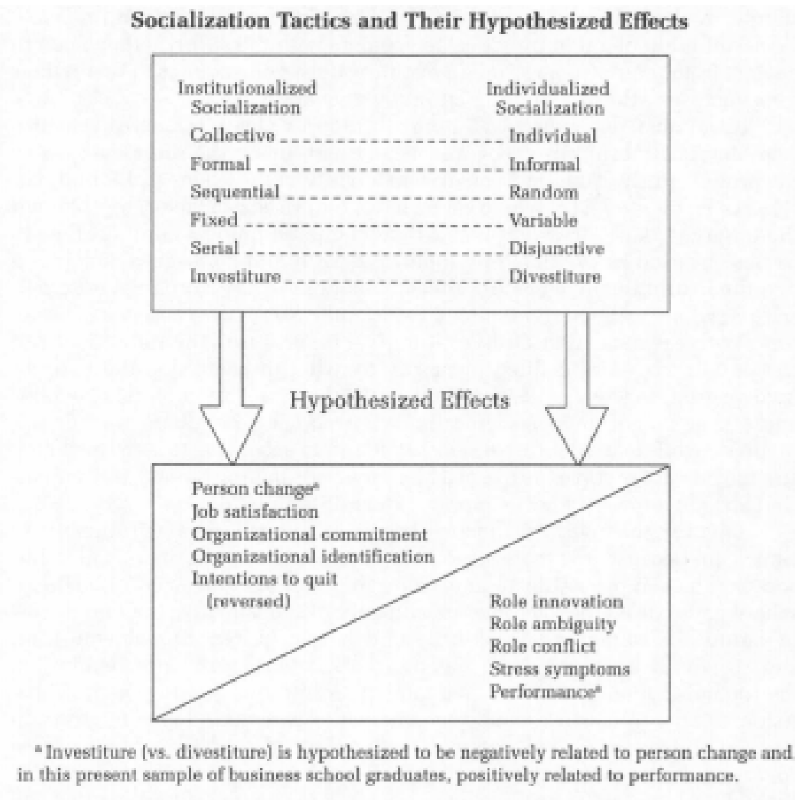

Figure 2.1. Socialization Tactics and Their Hypothesized Effects (Ashforth & Saks, 1996, p. 152)

Socialization can include a variety of components or tactics, such as formal and informal orientation, mentoring, social opportunities and networks, and critical reflection; all relevant towards improving workforce retention in public health (Snow, Hefty, Kenyon, Bell, & Martaus, 1992). Bucher and Stelling (1977) go into detail around socialization tactics and professional identity "dimensions." Components of their

dimensions include issues, tools, and methods; mission; conditions for work; relationship knowledge with clients, colleagues, and partners; and the relationship of the field to larger publics and institutions or posed as a question, “where does the field fit within society?” (p. 27). We see with Bucher and Stelling (1977) how early research into professional identity and socialization interchangeably used these terms. Later research demonstrates socialization as more of the *doing* and *tactics*, whereas professional identity as more of psychological outcomes of such tactics. Chao, O’Leary-Kelly, Wolf, Klein, and Gardner (1994) more appropriately describe six content dimensions relevant to new employees during their socialization process: politics, history, people, performance proficiency, language, and goals/values. Klein and Weaver (2000) add four foci/levels, to Chao and colleague’s dimensions: the job, the work group, the organization, and an individual’s trade or profession. It was hypothesized and shown that public health agencies utilize these dimensions and foci minimally and informally as part of their socialization efforts.

Kaufman et al. (2014) examined the newer crosscutting disciplines which can be embraced as emerging priorities for public health workforce development. These include: systems thinking, communicating persuasively, change management, information and analytics, problem-solving, and working with diverse populations. Each of these dimensions and foci detail a very complex web of socialization. Simpson (1979) also warns against reducing socialization to a matter of learning that is overly simple, stating, “processes do not only develop individually; their development may require separation from other processes, or, conversely, integration with other processes” (p. 167).

Support

Research has even ascended towards advising the specific level of detail within tactics that can be used to reshape socialization processes, from role-playing activities (Bucher & Stelling, 1977) to social outings and business trips (Louis, Posner, & Powell, 1983) to performing socialization in groups (Simpson, 1979). But by far, the greatest emphasis within the research calls for social support from within the organization or those who can serve as mentors, role-models, peer mentors, and peer groups. Such organizational roles are determinants in the effectiveness of the relational level function vital to identity development (Smith & Hatmaker, 2014). Bucher and Stelling (1977) reiterate the benefits that a strong peer group plays in professional identity development, positing that, “having a strong peer group can be very helpful to the individual trainee in traversing a difficult system” (p. 269). In their research of specific socialization tactics, Louis, Posner, and Powell (1983) found that the availability of peers, senior co-workers, and supervisors was a key aid to socialization, with their assessments that peers seemed the most beneficial to socialization development.

Mentors greatly contributed to newcomer socialization, but mentoring is rarely offered in public health (Wiesman et al., 2016) and when offered, is often not provided effectively. Peer relationships and the social dimension enhance organizational commitment (Filstad, 2011; Schaubroeck et al., 2013) and cannot be underestimated, given how these forms of support and acknowledgement lead to high satisfaction and ease of assimilation (Alhija & Fresko, 2010). Peers assist the formulation of career expectations and career choice decisions (Price, 2009). Appraisal from mentors and supervisors is the “strongest predictor of newcomer adjustment” (Bauer, Bodner,

Erdogan, Truxillo, & Tucker, 2007, p. 717) along with feelings of belongingness, whereby "feeling safe, comfortable, satisfied and happy" led to higher self-concept and self-efficacy (Levett-Jones & Lathlean, 2008, p. 107) and higher levels of trust. Mentors and peers lead to stronger commitment and better use of resources and information (Schaubroeck et al., 2013). Kammeyer-Mueller, Wanberg, Rubenstein, and Song (2013) found that, "proactivity is more likely when the appropriate initial social environment is present together with a pattern of continued support" (p. 1118); that support is ongoing, given that new trust relationships are formed throughout a career (Schaubroeck et al. 2013).

Agency

While peers and supervisorial role models have proven to be important in newcomer adjustment, so, too, is one's sense of self and locus of control even when professional roles are prescribed. A strong sense of self may lead to faster socialization and formation of a professional identity with less reliance on others. The necessity of agency may prove valuable in a career field facing a paradigm shift such as public health. Sporadic studies show that research towards an individual's agency and autonomy has taken a roller coaster ride over the decades in relation to socialization. In 1977, Bucher and Stelling found that trainees that they were studying were able to self-validate and use their own judgment as to whether they were doing well or not, showing that, "subjects took their *feeling* of mastery as *evidence* of mastery" (p. 212) and thus relied less and less on external validation from others; the result being an autonomous professional who has constructed his/her own professional identity. This led to a wide body of research, including Weiss (1978), who found that those with higher self-esteem

use their own judgement in new career situations and rely less on role models. Newcomers that possess the traits of self-efficacy will tend to be more autonomous in organizational situations even when their roles are prescribed (Jones, 1986), responding to situations in their own terms.

Clouder (2003) found the use of individual agency to improve or adapt to changing situations based on improvisation and adaptation. This use of agency is and will be vital to those currently experiencing the organizational and landscape changes that are occurring in public health because nationwide clarity will not likely soon arrive nor will a prescribed way of conducting business and care. More modern studies found both students and new employees self-directed and independent, with greater characteristic expression of individual proactivity, as compared to earlier socialization studies where conformity and moulding were perceived as expectations and norms (Levett-Jones & Lathlean, 2008; Melia, 1984; Smith & Hatmaker, 2014).

Outcomes

Socialization has been viewed as either a unilateral or bilateral relationship. The most negative of perspectives on this is from older belief systems where, “professional socialization is a process through which individuals are socially constructed and largely shaped into conformity” (Clouder, 2003, p. 220). This perspective is in direct opposition to the professional socialization perspectives where the individual acquires the social knowledge and skills to assume an organizationally more positive perspective which in turn guides the individual within the work realm but crosses over into one’s personal life when moving from outsider to insider status (Van Maanen & Schein, 1979). Public health employees, working in a profession without high pay and with little room for

hierarchical advancement, may likely form a professional identity that is integrated with their own personal identity, driven by a proclivity towards public service.

Research suggests that well-thought-out socialization programs, that include orientations and mentoring support, lead to retention, job satisfaction, and role clarity (Ashforth & Saks, 1996; Bauer et al., 2007; Jones, 1986). However, research has also shown that orientations are too short; and instead should span the first two to five years of one's career as opposed to the first few weeks or months (Anthony, Haigh, & Kane, 2011; Buchanan, 1974). Further efforts to increase socialization, such as induction programs and other workforce development training, are often underfunded and not an organizational priority (C. A. G. Crawford et al., 2009). With regards to public health socialization specifically, few if any standards exist with which to develop best practices examples. A recent case study of six local public health agencies' recruitment and retention tactics shared best practice outcomes for immediate practical use in the field. Such suggested outcomes included designing atypical job descriptions for a public health agency, agencies hiring young talent with unique skill sets, and connecting workforce planning to community needs (Darnell et al., 2013). This type of research, which shares best practice examples, will assist local public health agencies in the development of initial implementation ideas reflective of increasing socialization studies customized to public health responsibilities and the locus of their activities.

Learning Opportunities

But within public health itself, "most discipline-specific training never envisioned the scope of work and relationships with other professions and community groups required" (Amodeo, 2003, p. 501). Arndt et al. (2009) termed this as "interprofessional

familiarization," or learning about others outside of one's immediate discipline. They felt that a strong professional identity was necessary to work in an interprofessional environment such as public health. Snow et al. (1992) suggests that socialization engage the whole organization through integration of an organization's context and culture which in turn will offer employees broader learning opportunities, while the public health agency adapts "policy guidelines to match individual [employees] level of experience" (Anthony et al., 2011, p. 868).

Levett-Jones and Lathlean (2008) emphasize that in order to learn, new employees need to feel a sense of belonging in a caring, supportive, and team environment. They need to build social capital over an extended period of time to form trust and increase morale. This goes beyond individual-level socialization to the next level of creating supportive team environments (Hawley, Romain, Rempel, Orr, & Molgaard, 2011). Contrary to team building efforts, organizations that are deficient in mentoring and creating positive relationships, result in increased stress, inadequacy, and incompetence, thus hindering both learning and positive professional identity development (Levett-Jones, Lathlean, Higgins, & McMillan, 2009; Price 2009). This contradicts Louis et al. (1983), who suggest that just by using various socialization tactics (regardless of quality), organizational commitment and retention can be obtained from employees. Filstad (2011) found that formal training and career development (over informal) do not necessarily lead to organizational commitment. Others agree that socialization must be successful, and not merely just present, to lessen intentions to leave (Bauer et al., 2007).

Cervero (1992) posits that professionals learn through practical applications which lead to wise actions and that knowledge acquired from practice is necessary to achieve the goal of wise actions. He attempts to diffuse the opinion that education is superior to practical learning. His perspectives on knowledge ring true for public health since its workforce comes from myriad backgrounds and levels of education. Socialization efforts, being a form of practice, are a way to bring learning into work contexts which may provide employees with greater sustainability of their knowledge as opposed to mere coursework within classroom or on-line settings. When integrated into practice, socialization tactics embellish current everyday realities of a job and allow for potential lifelong learning relationships that have long term spillover effects to an individual's career and creation of a stronger professional identity.

Conclusion

Per literature review and findings, socialization concepts that were reviewed in my research include: time span for use of socialization efforts, stage of socialization at which each participant is currently in, when and where first socialization began (i.e. education or upon career entrance), extent of mentoring/socialization training via supervisors, current level of organizational commitment to socialization, and socialization tactics and assessment variables from the Van Maanen and Schein continuum. Learning topics being assessed within my research based on literature review findings include: politics, history, goals/values, systems' thinking, change management, and working with diverse populations. While a review of the topics may be most readily applicable in a practical sense for immediate use in the field, the most important aspect for long term increase in knowledge may well be learning how one's

socialization occurs and how well it is received as evaluated through the lens of the Van Maanen and Schein continuum.

Professional identity most often develops from socialization processes that derive from within both the education spectrum and in the workplace. Socialization tactics "provide newcomers with the tools they require to do the work that defines a professional. Socialization can also offer role models, mentors, and opportunities for interaction with experienced members of the profession. These individuals can guide newcomers as they make sense of what it means to be a professional in a particular field" (Smith & Hatmaker, 2014, p. 547). When critical socialization experiences occur for a newcomer to a profession, they aid in the development of a professional identity. Chitty and Black (2011) even go so far as to be determinate in stating that the "goal of [professional] socialization *is* the development of professionalism" (p.131). Adjusting ones lens to their chosen profession relates directly to an adjustment on their identity.

Professional Identity

Definition

Professional identity is not clearly defined. Researchers that have investigated this trait do not agree on a singular definition; instead they offer an amalgam of connections via career development or even career, occupational, or vocational identity (P. Crawford, Brown, & Majomi, 2008; Holland et al., 1993; Skorikov & Vondracek, 2011). This in turn coalesces into becoming a portion of a person's overall identity and sense of self (Johnson et al., 2012). Professional identity is more simply defined as "the perception of oneself as a professional and as a particular type of professional" (Bucher & Stelling, 1977, p. 213). In nursing, public health's largest cohort, professional identity

is referred to as “the psychological and social self-definition derived from receiving approval and positioning oneself in society as a result of fulfilling a social role through the specific occupation” (Okura et al., 2013, p. 9). Erikson (1956) viewed professional identity from the perspective of identity status development. Previously known as professional development, professional identity *formation* is defined as “a dynamic process that begins in undergraduate . . . education and continues to develop throughout one’s professional career” (Crigger & Godfrey, 2014, p. 376). It is important to note that research identifies the need for socialization to continue over time (Kammeyer-Mueller et al., 2013; Wanous, 1992). When dissecting the early perspectives from the more modern research, professional identity formation has become more complex studying vast social and psychological constructs.

More recent research posits that a move away from one definition of professional identity within a field is warranted (Clouder, 2003), and that the sum of a person’s knowledge, skills, and abilities be acknowledged within a diversity of professional identities from a person-centered approach (Hercelinskyj, Cruickshank, Brown, & Phillips, 2014). Having a strong personal identity leads to a stronger construction process of professional identity (Friesen & Besley, 2013). Allowing for individual and personality differences within a professional identity definition avoids a singular and fixed definition, and includes a “cluster of capabilities” (Hurley, 2009, p. 388), thus moving the study of professional identity away from early simplistic and monolithic definitions. All aspects of a person intersect with their profession, and if accepted by those within their profession, can lead to less impostership and less display of false or forced images of audacity. This shows a need for more intersectional types of

socialization programs, one that helps employees build self-value and realize their worth within a team, where their strengths are utilized and compliment other employees' strengths. I hypothesized that those who have a more individualized socialization with less institutional influence on their socialization experience, may also have a stronger professional identity, as a result of self-building. Data showed this to be false.

Later Development

Seminal researcher Ibarra (1999) goes further in her descriptions of identity-building aspects such as competence, trustworthiness, and creativity, whether well-defined or simply portrayed as a persona of such attributes. These qualities may be tested "as trials for possible but not yet fully elaborated professional identities" (Ibarra, 1999, p. 765). Instead, Ibarra labels these as "provisional selves" until one's experience informs the creation of a stronger identity. In other words, employees utilize many people to pick and choose which components they desire to create a fictional mentor. Development of provisional selves, their own role model, includes "observing role models to identify potential identities," personally experimenting with chosen and desired components, and self-evaluating using "internal standards and external feedback" (p. 764). Other research has also leaned away from the formation of a professional identity during one's education, or early career, instead showing that wisdom instead of knowledge, power, and agency help pivot one's career towards the development of a stronger professional identity (Ibarra, 1999; Kao & Lin, 2015; Wood, 2015), and such identity can dynamically morph throughout one's career (Monrouxe, 2010). My research may observe some of the phenomena of professional identity not

forming until well beyond the initial socialization period. The pool of selected participants came from those who have worked up to 7 years in the public health field.

Employees are constantly reinterpreting their professional and personal identities throughout their careers (Cook, Gilmer, & Bess, 2003; Kao & Lin, 2015; MacIntosh, 2003). This developmental phenomenon might explain the inability of new employees to feel formal acceptance and establishment of their professional identity early in their career (Wood, 2015). At a minimum, Hoffmann and Berg (2014), argue that professional identity cannot begin until one's field experience commences, whereby students transition from academia to a work-related career achieved through authentic work experiences, where mistakes are permissible. One study found that public health professional self-identity could not gain a firm hold in one's psyche until 6 to 10 years of actual work had been completed (Okura et al., 2013). Fagermoen (1997) likens professional identity to the "actualization of the values of dignity, personhood, being a fellow human, and reciprocal trust" (p. 439), especially for care-centric nurses, thus implying a later career formation. Within the nursing profession, a "nurses' professional identity appears to evolve from a general altruistic motivation to a set of values which are specific and differentiated . . . and revisional" (Fagermoen, 1997, p. 440). Of course, contrasting research shows that nursing students have a fairly strong professional identity upon program entry, more so if cognitive flexibility is strong, and if nursing students have previous work experience with emphasis on understanding the value of team dynamics (Adams, Hean, Sturgis, & MacLeod Clark, 2006). Other research posits and concurs with professional identity formation taking place during early education (Hayden, 1995), due to students' preexisting perceptions. Cook, Gilmer, and Bess

(2003) contrarily argue that pre-existing perceptions do not include more advanced concepts such as ethics, culture, and legal and economic issues necessary for a complete professional identity image.

Integrating Personal Values

A newcomer's personality and personal values, the newcomer's ability to seek information, and the context of the organization or role each affect professional identity (Vahasantanen & Billet, 2008). A newcomer may also be quite surprised that what they expected as an ideal professional is different from reality once entering their career, thus affecting their perception of professional identity (Melia, 1981, 1984). This baptism-by-fire feeling is common in public health because it is so nebulous to define until it has been experienced and because the idealism of the academic setting being challenged by the real world of bureaucratic and political barriers. It is incumbent upon new employees to move beyond and incorporate sought information into their own identity as a member of the profession, "the non-deliberate projection of themselves in its terms" (du Toit, 1995, p. 165), known as internalization, which differs from external views of one's professional identity. Ibarra (1999) also follows this stream by showing how employees use a great deal of internalization and reflection to determine their identity, in contrast to earlier seminal work that emphasizes a one-directional mentor-to-protégé feedback or supervisor-to-subordinate conformity (Van Maanen & Schein, 1979). Such "critical reflection on [Public Health Nurses'] experiences in communities of practice can strengthen the collective identity and legitimacy of the profession" (Dahl & Clancy, 2015, p. 685) with reflection, catalyzing the integration of self and professional identity (McCrae, Askey-Jones, & Laker, 2014).

Research Trends

Research into professional identity has moved from the focus on simplified tactics and schemas towards embracing a deeper sociological and psychological understanding. The internal struggle and negotiation processes that a newcomer endures within an organizational setting have been reviewed through Solution Focused Therapy (SFT), a practice most utilized in healthcare due to the client-focused nature of the profession. It allows an employee to be actively and autonomously involved in the professional identity building process. Noll (2014) describes five different professional identity negotiation approaches on a continuum; from compliance (i.e., following taught protocols and methods as is) to cooperative (i.e., finding solutions together) to directive (i.e., taking lead with input from others) to doing what works (i.e., creatively deviating from taught methods) and finally, to commanding (i.e., taking control/charge and refusing taught methods without involvement of clients or others, respectively). Noll (2014) studied how, “these different strategies offer a new way of understanding how professional identity is negotiated” (p. 4).

In contrast to the SFT interactive process described, Crigger and Godfrey (2014) emphasize that the social dimension of nurses’ professional identity (following rules, codes, and standards) will lead to professionalization, albeit in a more rule-following passive manner or through two other models: the linked Framework for Nurse Professionals (FrNP) structural model and the Stair-Step Model of Professional Transformation (Stair-Step Model). Crigger and Godfrey (2014) explain how, “the FrNP provides a conceptualization of professional practice and how ethics is the foundation of everyday practice. The Stair-Step Model provides the longitudinal perception of

professional identity formation and professional growth over one's career" (p. 380): again looking more holistically at professional identity development.

Kaiser (2002) argues in her study of medical students, that a passive professional identity process (where an employee denies uniqueness and reflection in order to meld with a fixed power hierarchy that exists in a profession) decreases self-confidence and self-worth. This contradicts Jones' (1986) findings that a passive identity forming process produces less ambiguity, role conflict, stress, and higher job satisfaction. A professional identity process that results in "radical change in self-identity" (Crigger & Godfrey, 2014, p. 377) is one that is viewed as more successful. In contrast to the social paradigm (where professionals perform in a prescribed way such as with the military, police, and fire), the psychological paradigm focuses on the professionals engagement with virtues, ethics, and character development. Both socialization and internalization need to exist simultaneously for complete professional identity (Crigger & Godfrey, 2014). My research examined such contrasting ideologies to determine the prominence of public health agency approach used and processed.

MacIntosh (2003) found that when nurses "encounter discrepancies that stimulate feelings of dissonance . . . [they] work to develop strategies to address those discrepancies and reduce the dissonance" (p. 730), thus developing professional identity. Her research found three stages of professional identity development: assuming adequacy, realizing practice, and developing a reputation. In the first stage, opinions of others are sought less, reflection is low, and task orientation with technical procedures is the modus operandi for newcomers. In the second stage, nurses begin to recognize values of self and others and attempt to balance discrepancies between what

they learned in education and what they experience in the career. Balance may occur in seeking additional professional development and stronger advice from peers and clients. In stage 3, nurses use their experiences to develop a reputation of competence and expertise based upon standards that further constructs their professional identity. MacIntosh (2003) also identifies three contextual factors that affect professional identity formation: expectations, perceived status, and supportiveness.

Identity Threats

The greater an employee's confidence level within an organization, the stronger the association was towards manifesting a professional identity (Okura et al., 2013; Wells, Ryan, & McElwee, 2000). However, setbacks can occur at any phase of professional identity development within a career due to lack of proper guidance and socialization (Okura et al., 2013), lack of supervisor training or an inability to deliver socialization along with aspects of social learning (Wood, 2015). Early external influences such as early stereotypes and prevailing opinions about a profession prior to entry can play a role in hindering professional identity development (Hoekstra, Van Meijel, & van der Hooft-Leemans, 2010; Wells et al., 2000). Outdated marketing materials serve as another hindrance to professional identity building in that they present unappealing images that can lead to incorrect preconceived notions of the field (Wells et al., 2000). During one's career, external threats can include perceptions of external pressures and expectations of the career (Kao & Lin, 2015) as well as incongruence between academic training and one's career (Pate et al., 2010) and status incongruence or invisibility of the profession with the general public (P. Crawford, et al., 2008; McCrae et al., 2014). One of the greatest threats, a lack-of-recognition

feeling which may or may not be a problem in public health, not only makes identity development more difficult to attain but also affects recruitment and retention of new employees.

Similar to the obstacles of professional identity formation, one researcher found that “professionalism, it seemed, was maintained by negative reinforcement” (McCrae et al., 2014, p. 771) such as employees avoiding disciplinary actions or being labeled as a poor professional. They determine that traditional nurse training, for example, which includes compassion and empathy does “not readily convey a clear professional identity” (p. 772) because of the pragmatism of viewing nursing duties as everyday tasks. Another failure in professional identity development occurs in professional associations, where professional boards of associations set the bar too high because many board people have years of experience already, thereby creating unachievable ideals for others just entering careers or in mid-stages of development. This can lead to feelings of non-accomplishment and impostership (Webster-Wright, 2006).

Impostership, a feeling of ineptness whereby a person presents a strong public image of competence masking fear of failure and not living up to the credentials or stature they have earned, is said to affect nearly a majority of professionals and students (Matthews & Clance, 1985). It is a fear that “their achievements are undeserved and worry that they are likely to be exposed as a fraud” (Sakulku & Alexander, 2011) even though their accomplishments and intellect may be vast and even while continuing to fulfill their work duties with success. While a professional identity may look “clear and clean” from an external perspective, a group may be “not only divided from the rest of society but also divided internally” (Kaiser, 2000, p. 98).

Egan (1989) even argues that the downside of professional socialization may be the destruction of self-concept if not consistent with previous experience. Impostership appears in the employees of public health, largely in a non-clinical sense, given staff from varied backgrounds and difficulty in defining success in the field.

Public health threats and barriers to building professional identity are connected closely to external factors including economic issues, time, those who resist change, and untrained or negatively seasoned employees (McKinney et al., 1998). The recently developed Patient Protection and Affordable Care Act (ACA) is also a newly created threat to professional identity development because it emphasizes a reduction in overall healthcare costs while seeking to improve upon the quality of care the patient receives, but is balanced against changing demographics and constant technology innovation within an unsure political environment.

These threats expose the concerns stated in the Introduction to this research. Some scholars denote that professional identity may progress little beyond education; that upon entrance to a career, professional identity becomes superficial, displayed in “surface behavior,” and lacking “deep attitudinal commitment” (McCammon & Brody, 2012, p. 259). Others found that support for newcomers declines after the first 90 days of employment (Kammeyer-Mueller et al., 2013). McCammon and Brody (2012) explain how:

> This can be imagined as an “onion” model of character formation, in which the most superficial layers represent knowledge of and adherence to principles or duties; the deeper layers represent the gradual internalization of the related

> values by deliberate practice; and the core represents the ultimate development of virtuous character. (pp. 259-260)

A major concern for this research was whether newer public health employees can develop a professional identity given the threats to its formation and the turbulent changing landscape of the field.

Circumventing Threats

However, in the field of public health, where employees come from a wide variety of backgrounds and education, this research assumed a professional identity that largely forms *upon* career entrance. Dall'Alba (2009) has taken a newer approach to professional identity formation, arguing that it should embody ontological considerations, with a focus on "becoming the professionals in question, not simply knowing as an end in itself" (p.35). The former represents the psychological (being) paradigm of professional identity development that presents similar to other studies of the past decade in addition to the social (doing) paradigm.

Benner, Sutphen, Leonard, and Day (2010) internalize socialization in a way that they suggest naming *formation,* to counteract these downsides to professional identity formation, describing it as, "the practitioner's evolving experience from that perspective, while socialization describes the social forces and influences on the person's formative experience" (p. 86). Their view is for organizations to develop new employees' self-understanding through the use of "transformation and reflection on formative experiences" (p. 88) in a more constitutive and transactional approach to identity building which helps to enhance identity beyond the simple performance of critical thinking as suggested in strengthening identity (Dahl & Clancy, 2015). Kao and Lin

(2015) also suggest the use of transformational leadership to enhance professional identity. It is clear that a one-model of socialization does not fit all. Some of Benner's work seems to modernize what Schein began in the 1970s.

Schein (1978) identifies various self-perceived traits of one's professional self-concept based in "career anchors" such as talents, abilities, beliefs, values, motives, and experiences; new employees use these to define their role within their profession and organize their experiences. He, too, stresses how crucial it is for managers to recognize individual differences "so that psychological contracts can be developed which accurately reflect the needs and expectations of the person in the career" (p. 128).

Formation of a public health professional identity might be lacking in the United States because there is not a direct route from education into practice and where there is no formal professional transitional examination. In England, one becomes a public health insider upon passing an examination, but there, insiders later "felt their identity was based more on their working relationships and not their examination results" (Wood, 2015, p. 4). "Insider" development then shows a need for both knowledge acquisition via education and workplace training as well as social interaction for professional identity development. Yet here in the United States, "public health is silo-driven without a unified consistent identity" (Kaufman et al., 2014, p. 563), even though there does exist an optional professional certification. This brings up the question of whether or not a unified national public health professional identity is possible for the field. In fact, efforts such as "This is Public Health" and "Public Health is Everywhere"

exacerbate the perception that public health is everything and therefore not one tangible thing in particular.

Even if both internal and external factors were in perfect order and implemented, Jenkins (2014) found that when employees share the same professional identity, they can interpret it differently, from both external practice and internal personal viewpoint. Thus, it is demonstrated how professional identity can be carried out differently from person to person. Hoekstra, Van Meijel, and van der Hooft-Leemans, (2010) and Wells, Ryan, and McElwee (2000) expand upon this concept by suggesting that personal experiences, perceptions, and stereotypical views play a part in professional identity development. These experiences contribute to professional identity building with the addition of any images a newcomer has been exposed to and stories they have heard, whether a true or untrue portrayal of the discipline. Government departments and professional associations can also have an enabling or constraining effect on one's identity construction (Chreim, Williams, & Hinings, 2007, p. 1516): either in that they provide professional development opportunities, which aids identity development, or constrain individuals by being "moulded to a particular mindset" (McCrae et al., 2014, p. 768). Professional associations may be unwilling to accept job role changes of members (Chreim et al., 2007), and are usually only helpful for those that are particularly motivated and active within the association.

Conclusion

Professional identity development and maintenance is a career-long process (Cook et al., 2003; Kao & Lin, 2015; MacIntosh, 2003), constantly evolving and depending upon context, transitioning an employee to a new way of life that can be

quite shocking (Duchscher, 2009; Kramer, 1974). Professional identity needs to be solidified in order to improve the quality of practice through error avoidance and better thinking about consequences of actions. This is especially pertinent to the field of public health where some employees may “not have a clear perception of the specialization of their field and thus experience a professional identity crisis” (Okura et al., 2013, p. 8). Training outcomes, self-identity and understanding, and managed academic to practice transitions can have a significant influence on professional identity and subsequently the retention of employees (Cowin & Hengstberger-Sims, 2006; Duchscher, 2009; Johnson et al., 2012). Altering training and curricula to include some of the perceptively latent components of public health (e.g., communication, finance, health policy, law, cultural competence, and ethics) can prepare public health professionals for a deeper understanding of their professional identity (Cook et al., 2003), since early perceptions of a public health professional identity may not include these components.

Not to be confused with organizational identity or professional role identity, “professional identity” identified in this research sought to determine the extent of commitment to a public health career, not merely a commitment to the agency itself or even a job title. Professional identity within the public health field may follow the career taxonomy, tenets, and values of a public health professional as “educated in public health or a related discipline who is employed to improve health through a population focus” (Gebbie et al., 2003, p. 4). For purposes of this research, “professional identity” was understood as the characteristics of the professional group that is public health, distinguishing it from other groups and professions whereby recognition of such professional identity was coalesced from the reflective experiences of public health

workers' practices from post-education to agencies where they experience workplace learning.

The following concepts were reviewed with extra clarity when describing the early career experiences of participant's professional identity given their denotation in this literature review: sense of service/calling; professional association activity; sense of autonomy/agency and how identity is negotiated; integration of professional identity with personal identity; critical reflection/internalization; development of "provisional selves;" external influences; and career entry shock/expectations. While each of the concepts relate to the other, this research denoted which concepts are prominent or hold prominence in shaping a course for the building of public health employees' professional identity.

Organizational Context

Definition

Many studies to date have focused on socialization tactics and outcomes using haphazard sets of participants. Thus, there has been a lack of concern given within such studies to deep organizational context reflection in relation and its relationships to both socialization and professional identity. Ashforth and Saks (1996) argue:

> Most conceptual and quantitative empirical work on socialization effectively ignore macro factors, such as the size, structure, mission, and culture of the studied organization (or relevant sub-unit) and the occupation, and meso factors – such as intergroup dynamics, leadership styles, technology and job design, and reward and communication systems. (p.175)

There exists a lack of empirical research systematically applying measurements of organizational context and this lack of systemization has occurred due to the broad and ever-changing list of characteristics. The list of potential organizational contexts and factors is infinite and equally difficult to define. Yet it is important to start somewhere in critically reviewing organizational contexts with socialization and professional identity.

Deal and Kennedy (1982) define organizational culture quite similarly to how others more recently have defined organizational context. They see it as the informal rules, guiding behavior, and leading to values, heroes, rites, and rituals that define the environment, thus increasing productivity and building a cohesive network. Needle (2001) defines organizational culture as, “both a set of distinguishing features . . . and a set of universal principles guiding best practice” (p. 40).

As with professional identity, organizational environment and context also can be deconstructed via their external and internal factors. External context includes political, economic, social, and technological factors (abbreviated as PEST); and known as an organization’s uncontrollable factors. Internal context focuses on service offerings and governance (Pojasek, 2013). To understand the hierarchical context of a local public health agency, it is important to note that the *parent organization* of a local governmental public health agency is the taxpaying public; the *enterprise* is the city government; examples of the many *work units*, or specializations, include epidemiology, public health nursing, health education, and sanitarian; and the most individualistic level includes numerous work roles within each health department.

Specialist Versus Generalist

For this research, organizational context questions focused on whether one identifies themselves as either a generalist or a specialist within the public health profession. This research focus is pertinent to urban areas where large health departments tend to have more specialists within the department to carry out responsibilities. A specialist is defined as someone who "attracts high value and worth, with expectations of highly developed knowledge, skills, and competencies toward complex and challenging phenomena" (Hurley, 2009, p. 385) about a particular public health issue, say a certain subset of communicable diseases, or who specializes in a particular group, say child health (Edgecombe, 2001; Koon, Goudge, & Norris, 2013).

Large health departments have the ability to specialize via one public health nurse for example, who can serve as the main point of contact for all asthma-related questions. But a suburban or smaller health department cannot afford to have as many staff specialists on board. Therefore, smaller public health department staff have to serve and act more like generalists, that can enact "whatever public health programs are required to meet the public health needs of disadvantaged and at risk-groups living anywhere in the community across the lifespan" (Edgecombe, 2001, p. 8). These programs vary from community to community and "are designed to meet the specific needs of the individual community" (Edgecombe, 2001, p. 8). Specialist public health workers may view these "jack-of-all-trades" public health workers as having lower professional status given their diversity of roles (Hurley, 2009), and because they do not have the luxury of time nor available resources with which to hone their skills into expert-based status. As generalists, they know a fair amount about many things, yet

Hurley (2009) argues by that all public health workers can be considered specialists in that “no other discipline can do what they can do” (p. 385).

This specialist versus generalist difference within a public health organization was predicted to be a key determinative construct to professional identity building, socialization, and context in this research. It was anticipated that focus on this concept will increase knowledge and provide broader application for socialization within public health departments across the country. Specialization versus generalization relates, and is synchronistic, to the lack of formal public health training among the workforce nationwide and determinative to the socialization itself. Today’s public health specialists may need to be tomorrow’s generalists. Kaufman et al. (2014) deduce that, “decades of categorical funding created a highly specialized and knowledgeable workforce that lacks many of the foundational skills now most in demand. The balance between core and specialty training should be reconsidered” (p. 557). In addition, it is characteristic for federal grant requirements to add roles onto state and local public health agencies while “previous functions are seldom jettisoned” (Beitsch, Brooks, et al., 2006, p. 919), creating additional workloads. Beitsch, Brooks, Menachemi, and Libby (2006) conclude that “public health is not funded well enough to meet the demands and expectations of an aging population that is further threatened by terrorism and natural disasters” (p. 920). Such stress placed upon employees and departments compounds the lack of any resources or time for professional identity building.

Organizational Concepts

Utilizing the seminal work of Ein-Dor and Segev (1978) in part, the organizational contexts in this research included: size of the organization/local public health agency

(measured by workforce numbers), psychological climate (attitudes, expectations, perceptions toward the department and work), and management status. Consideration of these organizational contexts is important for this research and to the field of public health, because there are a wide variety of contexts within and between neighboring local public health agencies even from within the same region.

The choices for this research were in line with Mason and Mitroff's (1973) seminal work in organizational context. They focus on two major components of organizational context—structures and people—while admitting that there are an infinite number of variables able to be used in assessing such organizational context. With regard to the structures, an agency's context is "influential in fostering continued professional identity development" (Crigger & Godfrey, 2014, p. 380). Organizational context, in turn, can be "strengthened by more formal procedures such as training and induction" (Needle, 1994, p. 147). With regard to the people component, organization demographics, work structures, and culture can either support or constrain the creation of certain role models and relationships and make these role models more desirable than others (Ibarra, 1999). This is important, because role models and mentoring relationships are key factors to socialization development as well as the development of professional identity. Figure 2.2 below demonstrates the progressive nature of factors needed to improve upon the satisfaction, clarity, and retention of new employees.

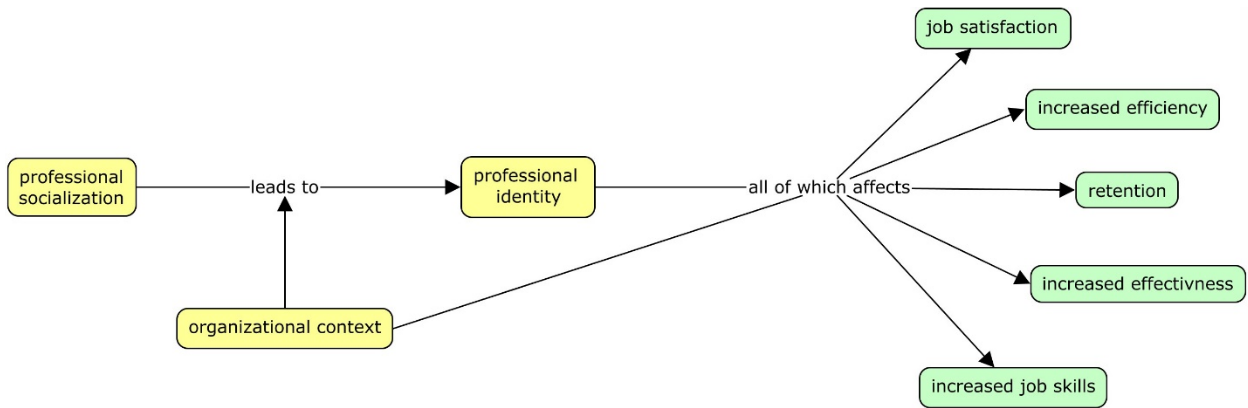

Figure 2.2. Progression of Socialization Aspect of Workforce Development

Conclusion

The next step in the progression of this socialization and professional identity research is to review specific organization professionals with regard to organizational context. Ashforth and Saks (1996) concur that "socialization, like any process, is interpenetrated with—and thus reflects—the specific setting and circumstances in which it unfolds" (p. 175). Research conducted with special attention to organizational context will bring about more specific advances and actionable tactics that are directly relatable. In review, the organizational contextual concepts that were reviewed with this research included: role, time in agency/career, autonomy, job feedback, size of the organization/local public health agency (measured by workforce numbers), psychological climate (attitudes, expectations, and perceptions toward the department and work), management status, and context with regard to specialist versus generalist stemming from task identity, skill variety, and task significance.

These components were used in this research in the development of interview questions for public health workers in local public health agencies. Each of the concepts

selected were reviewed with participants through interview questions to determine how they may impact professional socialization, professional identity building, and organizational context, and may affect how local public health departments create or reform any existing socialization programs and activities. These concepts relate to one another in that they provide a practical road map for health departments through which they can align their own socialization practices and to customize best practices to their own unique staff structure.

Filling the Gap

After reviewing the literature drawn from allied disciplines to public health (given that there is no literature on socialization and professional identity for the field of public health), this research begins with a review of historical studies. Such understanding of an effective starting place to socialization and professional identity in public health is necessary to identify gaps within the field around this concept. Literature was chosen for its applicability to public health, given the many avenues the findings may take. All literature was chosen for its ability to answer the three foundational research questions. As with any research, there are both supportive and antithetical findings to this research's concepts.

Examination of the identified concepts selected for pertinence in this research for socialization, professional identity, and organizational context will contribute to the extension of knowledge in the field of public health. These particular concepts were chosen from the literature because they are most readily applicable to current public health issues. The concepts are all interwoven, since they relate to the field of public

health and will provide a solid base into the topic of socialization and professional identity within public health.

Older socialization research focused on information being passed onto a passive newcomer. Modern 20th century socialization research literature targets the sense-making abilities of the newcomer to make decisions and select the most positive components from self-selected role models. This self-directed view is pertinent to the new paradigm of public health where rapid and politically attuned decision-making is necessary for effective public health work. With the majority of current leaders and mentors in public health from the pre-9/11 workforce cohort, it was interesting to note which leaders socialized employees with a focus on a more modernistic approach. The professional identities of the pre-9/11 and post 9/11 cohorts were somewhat different.

Researchers are replete in agreement that the most important variable in successful socialization is social support obtained from supervisors, other leaders within or outside of the organization but still within the field, and especially peers. While this is a strength of the vast majority of research, it may be a weakness in this field if it is found that social support is low. More detailed tactics have proven successful in other fields including rewarding high-functioning employees, staff retreats, better top-down communication, more joint decision-making opportunities, and flexible schedules without overtaxing workloads (Campbell, Fowles, & Weber, 2004; Pourshaban et al., 2015). A recent case study of local public health agencies showed promising practices such as: cross-orientations, using data to support workforce planning efforts, and incorporating behavioral competencies and emotional intelligence into workforce trainings (Darnell et al., 2013).

A looming vulnerability of this research was that findings revealed that public health agencies offer very little socialization efforts, which places this research back in even more historical and basic studies. This unexpected outcome was considered when choosing literature to support all of the various possible outcomes. A strength of much of the literature reviewed indicated that many of the research subjects within these studies had experienced some form of socialization. Nursing, medical, and teaching fields have learned that they are unable to survive when socialization activities, programs, or processes are not presented to new and existing employees, for without these programs, professional identity is hindered. This research sought to investigate public health's status on the socialization spectrum and help determine how the field may move forward. What this research adds to scholarly literature is a qualitative study with the use of empirical methodologies in a field that may not yet fully grasp socialization concepts, or is at the very beginning of attempting to grasp the gravity of their workforce exodus and therefore need to "stem the tide."

Key Study

A few articles resonate and provide grounding for the need for this research in the field of public health. First is a research brief about the workforce shortages placing the nation's health in peril. Draper et al. (2008) cut right to the quick about how dire the workforce crisis is within the public health field. While not specifically mentioning socialization or professional identity, they emphatically point out the need for the criticality of training and retention within the public health workforce, and that a lack of offering of formal orientations and succession planning in local public health agencies contributes heavily to this crisis. Five years later, this issue still looms large for public

health as shown through the Robert Wood Johnson Foundation funded briefing and study: *Local Health Department Workforce Recruitment and Retention: Challenges and Opportunities* (Darnell et al., 2013). In their review of the top ten local health agency retention strategies, results showed that only one is related to the socialization aspect: mentoring, which is key socialization component but insufficient if it is the only component used. The other nine factors include financial incentives such as paying for conferences, trainings, continuing education credits, and flexible hours. This survey was remiss in not offering many empirically researched options to choose from for retention strategies, but identifies this gap, stating “many health departments draw from a fairly limited menu of recruitment and retention strategies and may benefit from expanding their range of options” (p. 30); the barriers of which, they advise, need further research--providing basis for this research.

Darnell et al. (2013) had a study that was similar to this research in that they were trying to provide immediate practical best practices to those in the field: perhaps a way to ignite change while other research occurs to iron out the wrinkles. This reinforces the direction of this research by trying to speak to and provide ready examples to the non-academic minded public health audience. This research adds to Darnell et al. by increasing the depth of understanding and adding to the best practice examples. Quite surprisingly, Darnell et al. (2013) found that local health agencies were more concerned with retaining currently funded positions than about recruiting and retaining well qualified individuals.

Overall, the literature reviewed largely misses measuring via indexes, scales, rubrics or other means in assessing how one becomes professionally socialized

resulting from various processes or where in a socialization process one is. It also lacks matching specific socialization methods and tactics to overall “success on the job” outcomes beyond job satisfaction, role clarity, and intentions to leave. These ties are imperative for those in public health to understand when setting workforce development policy and creating reform of existing processes.

Conclusion

This research is timely, because the current climate in the field of public health is one of instability. First, the healthcare landscape is changing amidst a tumultuous political environment. Public health, being largely part of government structures, needs to sway with changes and attempt to remain relevant all while holding down a stable workforce, protecting the public from communicable diseases, potential terrorist attacks, and much more. Second, retirements are looming large in what has been coined as a mass exodus from public health. Third, after 9/11 and the subsequent anthrax scares, the federal government granted large sums of money to states and cities in an effort to prepare the public health workforce for natural disasters and bioterrorism emergencies: a dramatic new paradigm for public health employees. But, funding is on a constant decline in both grants and state and local tax levies for public health without any decrease in duties and requirements. All of this is both threatening the health of the public and forming a perfect storm for a public health professional identity crisis. A partial solution exists. Professional socialization processes serve a vital role in assuring that employees are not only competent and prepared to do their jobs, but that employees will remain in the field with higher levels of job satisfaction and performance.

Current public health leaders that might find this research valuable and applicable may be found at the local, state, and national levels. Additionally, public health leaders in non-profit, policy, and advocacy organizations may use the analysis. Public health programs at the organizational and university levels will want to look at this data to incorporate in their professional identity beginnings and bridge to career. The data will resonate with public health in other parts of the country (or world) and to other public and private professional fields, especially those in nursing, medicine, and education, the particular fields that this literature review is focused. Some of this research closely couples and may be transferrable with the study fields of knowledge management and workforce development for future research. Other future research as to the socialization experiences of new public health employees and the specific components that aid retention should occur to further substantiate the effectiveness of this type of program.

At a minimum, more literature is necessary for practical application and scholarship around socialization in the public health field. Organizational changes such as the changing public health landscape presents identity issues for employees. Research is imperative at this time to put an end to haphazard implementation of socialization and reduce career uncertainty. A stronger professional identity is necessary to deter workforce flight. This research begins these efforts and provides a base for which future research can build.

Chapter 3: Methodology

Local context and local understanding are very important to this research. Such understanding ties the research to qualitative methods, allowing for a deeper description, rather than painting a picture with a broad brushstroke, as quantitative research portrays. The emphasis is on being able to understand workforce development at the local public health level. Local governmental public health agencies have their roots in assisting communities, working at the ground level where the "rubber meets the road." Qualitative methods have been chosen because of the ability of this methodology to elicit rich, thick descriptions around public health socialization experiences, getting to the essence of the phenomenon of professional identity formation.

Philosophical Framework

Logic and Rationale for Choosing Qualitative Methods

Qualitative research impacts the public health field and can possibly stimulate a change to current ways of supporting new public health employees, especially if the essence of the research is described well, seeking to improve understanding of the issues that surround public health professional identity formation and socialization processes. Quantitative research, by comparison, cannot explain as well because there is little allowance within the methodology for illumination of change possibilities. Public health leaders read research for accreditation purposes and may change current practices based upon suggestions made within studies they read.

Using qualitative method allows the data to not be bound by "tight cause-and-effect relationships among factors, but rather by identifying the complex interactions of

factors in any situation" (Creswell, 2007, p.39) as I explore this issue of social inquiry. In other words, the voices of the public health participants will be heard.

Research Questions

As introduced in Chapter 1, this study answers to the following three research questions as they pertain to public health professional identity formation, socialization processes, and organizational context effects:

- How do urban public health employees experience the professional socialization process within their profession?
- How do the organizational contexts elicit or diminish professional socialization processes in the field of public health?
- What influence does the professional socialization process have on the formation of a public health professional identity?

Design Considerations: Specific Qualitative Approach

For validity in the field of public health, pattern formation across the responses and experiences of a number of diverse public health professionals and across a number of settings (or agencies) were investigated. Phenomenology was the design approach for this study.

Phenomenology is a philosophic attitude *and* a research approach in the interpretivist tradition. It aims to reveal "meaning rather than arguing a point or developing abstract theory" and "leads to more thoughtful action through constructionism" (Flood, 2010, pp. 7-8). It attempts to get at the essence of an issue. Phenomenology is subjective and based upon participants' everyday experiences as they perceive them or as they exist with significance for them personally (Crotty, 1996). My role was to identify and study socialization from the content of responses and

experiences presented to me, describing the meaning of the participants' experiences and beliefs. The essence is about being conscious right after we experience something but before we make sense of it, known as pre-reflection. Participants were questioned as to whether they have given much reflection to their socialization experiences given that they had been employed between one and seven years.

There are two main approaches to phenomenological research: descriptive (eidetic), based on Edmund Husserl's philosophy, which is more structured, and interpretive (hermeneutic) which is more fluid, stemming from Martin Heidegger, a colleague and successor of Husserl. Phenomenology's development is most attributed to Husserl, but there are many offshoots of this philosophy. Husserl used the term "back to the things themselves" to describe how he uncovers reality. His approach is to find the beginning of a reality. He sees "Being" through a logic framework where theories of logic use meaning categories.

Hermeneutic phenomenology, Heidegger's more existential perspective, embraces the idea of fusing personal knowledge with what is learned through interviews and "represents a move from an epistemological to an ontological project" (Flood, 2010, p. 9; Heidegger, 1982); to go from logical discourse and the knowledge of meaning to a philosophical view of being and existence. It allows a researcher to feel more empathy as opposed to full bracketing (completely removing one's own biases and experiences as researcher) espoused in the Husserl end of the continuum. Heidegger sees "Being" as being beyond categorization (Crotty, 1996); not always able to logically classify and compartmentalize. Heidegger's interpretation of phenomenology allows a dynamic and fluidly reciprocal research approach that "uncovers and generates, rather than re-

presents, understanding” (Vandermause and Fleming, 2011). Given my experience in this field and with this topic, I employed the hermeneutic approach to phenomenology, because I am perfectly positioned to help uncover the meaning of professional identity in public health as opposed to merely understanding the essence.

Known as the “hermeneutic circle,” Heidegger describes “moving back and forth between an overall interpretation and an interpretation of significant parts of the experience” (Bradbury-Jones, Irvine, & Sambrook, 2010, p. 27). Beyond mere descriptions of individual experiences, hermeneutics looks for “what people experience rather than what they consciously know . . . influenced by the world in which they live” (Flood, 2010, p. 9). The Heidegger end of the phenomenological continuum was a better fit with this research given that it offers a more inclusive approach between researcher and participants, a method that seeks to uncover what is known and not known.

Sampling Strategy: Site/Participant Selection, Description, and Rationale

This research used purposeful sampling due to the study occurring in one geographical urban area where I have prior career connections. The setting is specific to public health and mainly to those working within local governmental public health. This medium-sized urban area is “average” in that it has a wide variety of departments, both the largest and smallest local public health departments in the state. The public health departments have social equality concerns similar to other urban areas such as income inequality, loss of manufacturing jobs, racism, crumbling public transit, and troubling school performance and graduation rates. These health departments have faced new and unusual communicable diseases as well as a workforce that struggles to

match the diversity of the population they serve. These agencies' turnover and retirement rates mirror that of national statistics. The urban area for this research is located within a decentralized system whereby each local public health department is a unit of local government, independent of the state health department, similar to 58% of states (Salinsky, 2010).

The sample consisted of eighteen "advanced beginner" (1-3 years) or "competent" (3-7 years) governmental public health employees (Benner, 1984, 2001; Dreyfus & Dreyfus, 1980). Participants ranging from advanced beginner to competent professional status were used in this study because of more recent experiences and memory of their induction and socialization experiences including experiences around what they know and have learned thus providing for a richer data field. New employees with less than a year's experience may still be in the thick of their socialization and learning experiences and therefore were not investigated, even though possibly more pre-reflective than the range selected for this research. Employees that have worked longer than 7 years, may not remember their early socialization as accurately, so this pool of workers was also eliminated from the research study. Those public health workers with 1 to 7 years' experience have enough recent memories of their socialization experiences as well as knowledge concerning changes or improvements to socialization that helped enrich the data base. The sample included a variety across the 1-7 year range, showing similarities and differences as time goes on in working in the field.

Van Maanen and Schein (1979) support this research's years of employment inclusion criteria. They cite that it is not until a newcomer has been tested and then

“granted inclusionary rights which then permit them to share organizational secrets” (p. 222) when the study of socialization tactics might have more depth. Buchanan’s (1974) research on three tenure stages supports this range of sample stating that more research is needed for those with five or more years of tenure to “understand how commitment is maintained at mature career stages” (p. 545) but also shows how those employed longer than ten years have diminished recollections of their first year’s socialization efforts. One study found that supervisor and co-worker support declines after the initial 90 days of employment resulting in decreased job satisfaction by the end of the first year of employment (Kammeyer-Mueller et al., 2013) which also proved to be a factor in this research.

Glesne (2011) refers to this type of purposeful sampling as maximum variation sampling, where my participants cut across a wide range of local public health agencies. Each agency is unique and provided different perspectives into the research, thus showing how organizational context is important to socialization experiences.

Entry, Rapport-building, Reciprocity, Possible Ethical Issues

This study was approved by the University of Wisconsin-Milwaukee Institutional Review Board (IRB#: 17.283 approved April 5, 2017) as shown in Appendix C: Institutional Review Board (IRB) Application.

First, emails to urban area health officers were used to gain participant responders contact information that have any new(er) employees with one to seven years’ experience. Once obtaining these newer employees’ contact information, I emailed to seek their interest in participating. These employees were role diverse including public health nurses, epidemiologists, sanitarians, and health educators.

The health officers of each of the health departments are very interested in this research, because very few have left their positions to obtain a PhD, which is highly valued within the field, and especially because they see that I will be doing work toward the overall good of public health. I have ongoing contact with the health officers that provided participant names and contact information toward this research. Findings from this research will be helpful when they report out to their city councils that their staff participated in a research study, thus keeping them current with research, a national accreditation requirement. Confidentiality was maintained in that the health officers did not know who of their newer employees chose to participate in the research, if any.

Ethical issues were minimized such as protecting the privacy and confidentiality of participants. Institutional Review Board (IRB) consent forms (Appendix D) were signed and collected from each study participant, and pseudonyms were assigned. Research questions, intentions, and confidentiality issues were explained to all participating in the study. My public health background and knowledge were used sparingly and only to reiterate an interview question or point, although I developed a slight connection with each participant through shared experiences.

Data Collection

The collection of data was obtained from recorded interviews with an iPhone microphone to MP3, (with signed consent – Appendix D: UWM Consent to Participate in Research), and notes on a laptop, all of which I had previously utilized. Laptop notes were structured according to interview questions (Appendix E: Individual Interview Protocol), whereby key words or phrases were jotted down, paying closer attention

during interview dictation. The iPhone MP3 recordings were saved on a password-protected computer for later transcription.

The interview questions were first piloted on one public health employee that was not part of the research process, to ensure the questions were appropriate in garnering experiences and answers to the research questions and altered as necessary. The interviews lasted between 51 and 90 minutes each. Each participant was interviewed once; the interview's purpose was to elicit preliminary information and uncover meanings from participants' experiences in socialization, thus, answering the first research question about socialization processes and partially the second research question about how organizational contexts affect these processes. Then, the interview sought to obtain clarification and further get into the inner voice or essence of the research questions. The interview ended with more philosophical questions and continued to answer the organizational context research question with the third research question on professional identity.

I asked each question from the Interview Guide (Appendix E: Individual Interview Protocol) and rearranged the questions order to accommodate ease in participants' answering, allowing each to have time to draw deeply into their thought processes. The interview were semi-structured in that the questions guided the interview, touching upon each subject area, but was open to adding or replacing pre-set questions as the dialogue emerged. Interview questions centered on the following topic areas:

a. Demographics (focus toward answering the Organizational Context research question

b. Prior to Career (focus toward answering the socialization and professional identity research question)
c. Early Training (focus toward answering all three of this study's research questions)
d. Psychosocial Support, (focus toward answering the Socialization research question) and
e. Philosophical/Future (focus toward answering all three of this study's research questions)

Each interview sought to gather the experiences/behaviors, feelings/emotions, opinions/values, and knowledge from participants (Patton, 2002).

Change of Method

With the first few participants, I realized that I needed to abandon direct questions or prompts about their professional identity (e.g. Describe your public health professional identity) because the concept was too hard to understand without a lot of prompting, that I felt was skewing their answers and opinions. Because of this, I needed to gather data on their professional identity via other questions (e.g. Do you think you have passed from being an outsider to an inside member of the public health profession? If so, at what point?) This adjustment to the interview questions garnered more interesting and detailed answers that I then related to each participant's professional identity status given the definitions of professional identity used for this research.

Data Analysis

Based on margin notes per dictated interview, significant statements and repeated themes were coded from verbal and graphic patterns that emerged. Pseudonym name codes were used for each interviewee (Table 4.1) in tandem with using color codes for various conceptual patterns. Coding initiated from detailed smaller concepts before advancing to larger themes, all of which guided the outline of describing the *essence* over any mere measurement analysis or simple descriptive explanation (Moustakas, 1994). Patterns emerged around initial professional training, mentoring, peer groups/social aspect, and future ideas. I used van Manen's (1990) data analysis tactic where the researcher "mediates" between different, and often hidden, meanings of the lived experiences (p. 26) and "seeks to uncover and interpret the meaning of being" (Doyle, 2007, p. 892).

The narrative analysis first went into detail about my experience of socialization, exposing any biases, then bracketing out prior knowledge, beliefs, and judgments. Bradbury-Jones, Irvine, and Sambrook (2010) explain: "Heidegger's point is that truth cannot be established by separating oneself from what is to be known" (p. 27). Writing in the second person allows the writer to take ownership of what the analysis indicates after bracketing out personal experiences (Hamill & Sinclair, 2010) and aids the reader to feeling immersed in the essence. Doing so aided in eliminating an embellished or massaged description and was followed by a textural description with participant quotes to compare and contrast. This shared and negotiated construction of the "truth" between the participants and researcher "is an integral aspect of understanding the

meaning of existence or a particular phenomenon" (Doyle, 2007, p. 892) and led to a more rich essence description.

Further, my analysis moved beyond elucidation and toward true phenomenological writing that makes the reader believe that it was an experience that they could have had, referred to as the "validating circle of inquiry" (van Manen, 1990, p. 27). For example, the data did not merely provide a description of what socialization practices occurred but described the participants' experiences and feelings toward their professional identity development. It went into a rich description about how and why they entered the field of public health and what ensued thereafter with regard to socialization.

The Moustakas (1994) modifications of the "Stevick-Colaizzi-Keen method of providing the most practical, and useful approach" (Creswell, 2007, p. 159) to phenomenological data analysis was utilized, less the infusion of my own personal experiences, since I no longer fit the criteria of having worked in the field only 1-7 years, thus my experiences were bracketed out. The order of this methodological process:

a. Record and list all relevant and significant statements for description of the experience (invariant meaning units);
b. Group invariant meaning units into larger themes such as: socialization (including orientation/induction), mentoring, training, belonging (professional identity), and organizational components.
c. Synthesize meaning units and themes. Provide *what* was experienced with a "textural description of the experience – what happened" (Creswell, 2007, p.159) with quoted examples.

d. Provide the *how*– the "structural description" of the setting, conditions, situations, and context.
e. Finally, a "composite description of the phenomenon incorporating both the textural and structural descriptions . . . [known as the] essence of the experience" (Creswell, 2007, p.159) was written for the group as a whole; in this case, the essence is a universal description of the issues surrounding new public health employee socialization and professional identity development experiences located at the beginning of Chapter 4.

Quality Control

Using strategies that Creswell and Miller (2000) proposed to validate qualitative research and in essence, build trustworthiness, the following were utilized:

Prolonged Engagement

Over the past 13 years, I have worked for and/or been continuously engaged with the local public health agencies that were the source of participants for this study. Trust has been built over this time with various agency leadership and staff. Engagement with willing study participants occurred via one interview over 2 months' time, with discussion of their current realities concerning the context of local public health in this urban region. I attempted to maintain my distance, not befriending each participant for example, as a way to objectively evaluate their statements to me, the interviewer.

Clarifying Research Bias

My own personal experiences and biases were detailed up front, in this research (e.g. my lack of a quality mentor when working in the field). I described my 9 years in

public health succinctly so that the reader knows what shaped my “interpretation and approach to the study” (Creswell, 2007, p. 208).

Rich, Thick Description

Providing a rich, thick description of participants’ socialization experiences and professional identity formation in the analyses may assist in data transfer to public health in other parts of the country (or world) and to other public and private professional fields. Some of this research closely couples and may be transferrable with the fields of knowledge management and workforce development. Building a relatable experience for the reader is vital for the seasoned public health employees in remembering their own experiences, and when using this research to make potential changes to their new employee protocols and succession planning. Creswell’s (2007) secondary criteria of “explicitness, vividness, creativity, thoroughness, congruence, and sensitivity” (p. 206) came into play here.

Positionality

When I entered the field as a post-9/11 employee, little socialization occurred. I was never formally assigned a mentor nor formed an informal mentoring relationship. Because I was not socialized into the field, a broader professional identity was not formed. Inductions and orientations were piecemeal at best. Instead, I identified with other newly hired post-9/11 workforce, and found many peer mentors through this group. We often talked about what our roles and where we fit in the broader public health picture. We were siloed as “that” grant and never fully enfolded into the larger vision of either the agency or the field, although we often looked for ways to bring emergency preparedness and our mission to everyday public health.

Through the following eight years, I began to see this peer mentor/post-9/11 hired group move on to other jobs and careers outside of public health. The following reasons were cited for their leaving: lack of leadership, lack of role definition, fear of money and positions diminishing, not being appreciated, and no room for growth and advancement. I could not help but wonder what was lacking in the field of public health that, if present, may have changed their minds or encouraged them to stay. This mass exodus of a new generation of public health workers perplexed me. It was a critical time in the field of public health, being graced with large sums of money and a bright new workforce, and yet more seasoned workers did not effectively encourage them to stay.

I graduated from three different year-long leadership institutes to become a better leader myself, but found that my improved knowledge and credentials were not as valued as I thought they should be in a field that was “retiring out.” Why did the current leaders not capitalize upon this rare opportunity? What could have been done differently to present a different outcome? These questions became the basis for my dissertation research.

Chapter 4: Findings

The purpose of this research is to describe how newcomers to the public health field experience professional socialization processes and how those processes create a professional identify. I first describe what a new public health employee experiences based upon participant responses. This composite description, written with deeply textural and structural details (Creswell, 2007) of what was experienced by a majority of participants, is written in the second person, to give an overarching example of what a new public health employee experiences. It provides a universal description of the issues surrounding new public health employee socialization and professional identity development experiences that should readily place the reader into a new public health employee's lived experience.

This is followed by a description of the eight local public health agencies and then the 18 participants using data I collected during face-to-face interviews. Finally, I offer an interpretation of the data gathered via hermeneutic phenomenology and the Moustakas (1994) modifications of the Stevick-Colaizzi-Keen Method of analysis whereby experiences are presented objectively using words and answers from the participants. Three themes and seven subthemes were identified, defined, and described through participant quotes that should enable the reader to further understand the lived experience.

A Picture of the New Public Health Employee Emerges . . .

True phenomenology attempts to place the reader within the lived experience. The following is written in the second person in an attempt to place you into the life of a

new public health employee based upon the conglomerate experiences of the 18 participants.

You are not happy in your current hospital nursing [or other] job and are having difficult situations arise that make you question what you really want out of a career. Your current position is very specialized and does not provide a great deal of autonomy or flexibility. You never really wanted to be in this position anyway. You would like to find a position in a more preventative side of health that includes education and working with the community. You search the Internet for jobs and discover a job in public health. You envision that this means working with local population and will provide you steady hours, including the flexibility to have your nights and weekends to yourself.

You applied, interviewed, and finally received a job offer after some long period of time. You almost forgot about the job you applied and interviewed for. Because of this, you begin to realize the cliché that "government moves slow" is not just a cliché. You are excited for this new opportunity even though you do not really know what the job entails or what the agency that hired you does. You imagine that because it has the words *public* and *health* in the title that you will be doing a lot of community outreach, educating the public about health issues. Your program in college did not teach you anything about public health.

The first day you walk in the door, they show you to your cubicle ("I get a desk?!") and provide you with a checklist of videos you should watch from a variety of online sources such as the Centers for Disease Control and Prevention, Homeland Security, and other online training systems. They may provide you with a stack of policy and procedure manuals to read, or you may find the drawers filled with the projects and

work of the previous person, who just retired. You wonder when you will be able to get out in the community and actually help people on their health journey.

After two weeks of reviewing (and not really retaining) all of these materials, you are feeling overwhelmed and wonder if you made the right decision in taking this position. There are so many acronyms. The people here have worked here for decades. It seems hard to make collegial relations in that some people are not willing to share their knowledge or programs—holding their work close to the vest. There do not seem to be any social events where you can get to know your co-workers better. The divisions within your department seem somewhat siloed in that there is little cross-collaboration.

After sitting at your desk watching one boring video after another, a co-worker comes to get you to show you a bat and a dog head that they must send off to the lab. You have never encountered anything like this before and never even knew public health handled this type of situation. But you suddenly see an opportunity to learn more, so you begin to ask a lot of questions even though you worry that it annoys your boss and co-workers. You just want to understand why things are done “the way they always have been.” You are very resourceful, so you use Google a lot to search out various diseases; you discover others nationally who have developed programs similar to the ones you have been assigned.

You ask your colleagues if you can sit with them or go out in the community with them to observe and learn. You are creating your own orientation to this role, because no one ever really taught you what your role was. In the coming months, you struggle between having a great deal of autonomy while trying to correctly behave within a

governmental structure and a hierarchy you do not understand and have not been trained on.

Some days are painfully slow and boring. You are trying to figure out what you can do to fill your time. Other days you are thrown into a new situation, such as a communicable disease investigation that has your days completely full and busy. On these days, you feel that you are in reactive mode and not able to stay on top of things or get anything done, let alone done well. But at least it’s exciting. You are now seeing how much bigger public health is and how many connections and resources are needed for this job. You felt thrown in at the start and had to create your own path, but you continue to ask more questions, read articles, and search for online trainings. You find that you are very good at locating the resources you need for all the new situations that arise. You wish you had a bit more direction or consistent meetings with your boss to make sure you are doing the right things.

Some co-workers are very possessive of their programs, not willing to hear new ideas nor share their projects or specialties with you. You have heard the term of some people being “Retired-On-Duty (ROD),” meaning that they show up to work but do not wish to lead, nor do they have a passion for the field of public health any longer. Public health seems stifled without open communication and cross-training. You want to share your projects with people in other agencies, but your boss frowns upon that. You want to get out to more meetings to network, but again, you must justify why that would be beneficial to your job. You discover that there is not a lot of growth opportunity in this field. You are allowed to go to state conferences and trainings, though, which is great for learning new things and learning about what others are doing in your similar position,

but you desire to take a more leadership role. You have the type of personality that finds a way to forge through all of this uncertainty and continue along toward the reason for why you came to public health in the first place.

A year into the role, you get used to the pace of things in public health and feel more confident, but you still do not feel fully vested in this career. You have fewer questions for everyone, although sometimes you feel unsure and are making decisions that you do not feel 100% confident about. You like having more autonomy to create your role and like that it is not so specialized and narrow in scope as you experienced in your previous job. But your prior expectation was not met in that you thought that working in public health meant that you would be working out in the community more often, educating and running programs. So you have adjusted to just being at your desk a lot.

You still hope to learn some of the bigger picture aspects from your boss, such as how the city council operates and where your funding comes from, but she is always busy. You really wish that you had had a mentor beyond your boss and cannot imagine where you would be without that peer group you have lunch with and vent to, now that you have finally found others to socialize with. At this point, you don’t really know where your career will take you, but you are settled for now because you do enjoy getting out and helping people when you are allowed. You feel empowered when you see a light bulb go off in a community member because of something you taught them. You don’t see a raise on the horizon, but the acknowledgement from your boss on that recent successful program leaves you feeling satisfied in public health . . . for now.

Contextual Description of the Agencies

The participants in this study work at eight different public local health departments in an upper Midwestern metropolitan area. The agencies range from the largest in the state, with approximately 250 employees and serving an urban core of residents, to smaller suburban health departments with varying full and part-time employees between six and 13 staff members. The urban area for this research is located in a state within a decentralized system whereby each local public health department is a unit of local government, independent of the state health department, similar to 58% of states (Salinsky, 2010).

These health departments exist in a state that is governed by "home rule," where local governments operate to pass laws and ordinances necessary for their communities within the confines of state and federal constitutions. Home rule gives these local health departments a level of authority to act independently and quickly in a public health outbreak or emergency. These eight health departments have worked together (alongside 11 additional health departments in the region) in various collaborative efforts for the past few decades, including but not limited to a Heat Task Force, Emergency Preparedness Consortium, and through an association of local health departments and Boards of Health.

While these agencies collaborate due to the tight geographic footprint of this metropolitan area, they are relatively independent entities with very different levels of programming and services depending upon the needs of their communities. The largest health department is composed of mainly specialists, with distinct divisions and departments that are rather isolated from the rest of the divisions within the public

health agency. The smaller health departments perform more as generalists, where each employee has an understanding of all the services of the health department, if not the ability to take on tasks within any other employee's role. The smaller health departments have a flat hierarchy, with health officers that will sometimes work among the ranks if needed. The larger health department has a steeper hierarchy, thus affording more opportunities for advancement.

Description of the Participants

There were 18 participants from eight different local public health agencies. Participant requirements prescribed that they had worked in public health at least one full year but not more than seven. New employees with less than one full year's experience may still be in the thick of their socialization and learning experiences and therefore were not investigated, even though they might possibly have been more pre-reflective than the range selected for this research. This research examined a range of employees, from "advanced beginners" with at least one year of experience to "competent" local public health employees with 3 to 7 years' experience (Benner, 1984, 2001; Dreyfus & Dreyfus, 1980). Participants ranging from advanced beginner to competent professional status were recruited for this study because of more recent experiences and memory of their induction and socialization experiences. Including experiences around what they know and have learned, this provided for more critical reflection and a richer data field. The sample included a variety across the 1- to 7-year range, showing similarities and differences as time goes on in working in the field. The median for number of years in the public health field was 3.75 (mean of 3.6 years) with 64.58 collective years among all 18 participants.

The participants included seven public health nurses, two epidemiologists, two from a public health lab, three that fall under a public health educator or specialist title (each doing emergency preparedness in addition to other program areas), two in environmental positions, and two other administrative specialties specific to public health. Six participants had supervisory roles, supervising from one person to eight people. There were 13 females (72%) and five males (28%). Two participants were African American and 16, or 89%, were Caucasian. Their ages ranged from 27 to 63, with a median age of 31.5 and mean age of 35.2. With regard to highest degree obtained at the time of interview, eight had undergraduate degrees, nine had a masters, and one had a doctorate (44% undergrad; 50% masters). For four participants (22%), public health is their first career right out of college.

Half of the participants are employed at the larger health department and all considered themselves specialists. The other half were employed at smaller suburban health departments, all considering themselves generalists, thus proving with definitive lines the split between the two types of public health workers.

Table 4.1 shows a comparison of the 18 participants, including some of the categories of: age, size of agency based upon the number of full- and part-time employees, if they are a member of the state public health association, if they are managers, if they are a specialist or generalist by role, if they had mentors or a peer group within their first year, if they considered themselves an insider or an outsider to the field of public health, which they allied themselves with more (job role, agency/community, or field of public health), and, in a very brief nutshell, where they see themselves in 5 years.

Table 4.1

Overview of Participants

Age Range	Pseudonym Name and Gender	Size of Agency Based Upon # of Staff	State Public Health Association Member	Supervisor of:	Job Role: Specialist or Generalist	Has or Had Mentor(s) or Peer Group Support	Insider or Outsider (~ = not 100% or reluctantly claiming Insider)	Most Allied with: Job Role, Agency/ Community, or Field of Public Health	See Yourself in Public Health in 5 years
27-30	Kailey (F)	Small	Yes	0	Generalist	~Mentor	~Insider	Role	Don't Know
	Anna (F)	Small	No	0	Generalist	None	Outsider	Role	Don't Know
	JJ (M)	Small	No	0	Generalist	None	~Insider	Agency	Don't Know
	Chelsea (F)	Small	No	>3	Generalist	Mentor	~Insider	Role	Public Health
	Jordan (M)	Large	No	0	Specialist	~Both	Insider	Field	Public Health
	Brittney (F)	Small	No	0	Generalist	Peer	Insider	Agency	Public Health
	Stacy (F)	Large	No	>3	Specialist	~Both	Insider	Field	Public Health but somewhere else
	Sheridan (F)	Large	No	>3	Specialist	Both	Insider	Role	Return to School Full Time
	Kalea (F)	Small	No	0	Generalist	Peer	Insider	Field	Public Health but promoted
31-40	James (M)	Large	No	0	Specialist	Peer	~Insider	Field	Public Health but somewhere else
	Carson (M)	Large	No	<5	Specialist	Mentor	Outsider (support role)	Agency	Not Sure
	Sue (F)	Large	No	>3	Specialist	Both	~Insider	Agency	Don't Know
	Katy (F)	Large	No	0	Specialist	None	Outsider	None	Not Public Health
	Dee (F)	Small	No	0	Generalist	None	Outsider	Agency	Don't Know
	Stephanie (F)	Large	No	>3	Specialist	Both	Insider	Role	Don't Know
45-65	Tami (F)	Small	Yes	0	Generalist	Both	Insider	Field	Don't know – possibly in Public Health
	Sherron (F)	Small	No	0	Generalist	None	~Insider	Role	Not Married to Public Health
	George (M)	Large	No	0	Specialist	None	Insider	Role	Public Health

Thematic Extractions

After all interviews were transcribed, all relevant and significant statements were listed for description of the experience, also known as invariant meaning units. These units were then grouped into 13 larger themes: how landed in public health, supervisor, expectations before entering, first days/weeks, socialization components experienced, proactivity/resourcefulness, support missing, mentoring/peer groups, empowerment/satisfaction, keys to success, insider status, ally with, future, and ideas for others. Through these initial themes emerged three major themes in answering the research questions, and seven subthemes, as outlined below:

Theme 1: Piecemeal Socialization (addressing research question #1: How do urban public health employees experience the professional socialization process within their profession?)

Subtheme:

Overwhelming first months

Pace: all or nothing
Thrown in—figure it out
Length too short
Forced resourcefulness
Lack of academic preparation

Theme 2: Programmatic and Hierarchical Isolation (addressing research question #2: How do the organizational contexts elicit or diminish professional socialization processes in the field of public health?)

Subthemes:

Lack of support systems

Boss as “mentor”
Deficient leadership
Importance of peers
Networking opportunities

Broader image missing

Strategic plans
Political and financial
Silos
Cross-training desired

Theme 3: Tenuous Professional Identity (addressing research question #3: What influence does the professional socialization process have on the formation of a public health professional identity?)

Subthemes:
False prior expectations = later satisfaction
Insider or outsider status
Feelings of impostership
Professional Memberships lacking

Chapter 5 discusses how each of these themes addresses each of the three research questions. It also discusses implications and recommended actions for public health leadership, education, and future research in addressing the issue and creating change.

Theme 1: Piecemeal Socialization

Each participant had bits and pieces of socialization, but no one had a complete socialization strategy as defined in Chapter 2. The components of socialization that each participant received were often unplanned and sporadic, lacking commitment to a purposeful program and true onboarding.

Overwhelming first months. As with any new position, those first months can be quite trying, but the descriptions below will detail the difference for those in the public health profession. Overall participants repeatedly discussed how they felt overwhelmed during those early months: overwhelmed in the sense that things were so vastly different from their previous experience and knowledge but not in the sense that they could not handle the position.

Pace: All or nothing. Many of the participants expressed a similar feeling upon entering the field of public health: that it was overwhelming, whether the pace during those first few months was fast or slow. Exactly half of the participants expressed that they had been on the go since day one, such as Sue, who said, “So I stepped into a role

that hadn't been filled in 2 years, and then literally on the first day, I hit the ground running handling [the job]. Didn't even have time to develop a plan or anything." The other half expressed how slow those first few months were, such as Chelsea, who expressed that the first few weeks "was kind of like, oh my gosh, if I have to sit and watch another video I'm going to go insane." Similarly, JJ said:

> I spent the first week just organizing my office because I had no direction or clue what the hell I was doing. . . . And part of me is thinking, is this what I'm really going to have to do for 4 years—sit in a cubicle? So I was kind of panicking, like did I make a mistake? And I had that same thought a few times as the year went on, because some days it was just God awful and boring, and I'm like, "Do I really want to do this?"

Thrown in—figure it out. Whether the pace was fast or slow, that overwhelming feeling resounded throughout the participants' responses. Carson succinctly stated, "It was just a crash course, and then 'in you go'." Dee said, "I felt like a lot of that stuff is thrown at you right away. I remember getting signed up and all these passwords for all these different programs and not having a clue on what they were for." Kailey detailed that "you are sometimes thrown into new situations, like within my first month, we had an outbreak. So, okay, you're going to do all of these follow-up calls now. In my second week, I had to ship a bat." Tami expressed that the topic of emergency preparedness was:

> . . . thrown at me. I had no experience with preparedness, which is a shame. . . . [We were sent] this list of things that we needed, and they handed them over to me, and I would go home, and I would feel shell-shocked because my entire day

> was: I need to figure out this huge binder, and I have to take these ICS Courses, and I have to take these courses on these acronyms just flying at me, and next week I have a meeting with the fire and police chiefs, and I don't know what I'm doing, and this is not what I thought it was at all. Besides the fact that starting a new job, those first couple of weeks is just awful.

Anna learned about diseases on the fly and "learning by fire." Stephanie had a comment to the effect of:

> I was so overwhelmed, it's like I barely remember what happened that first six months . . . it was a pretty big learning curve, so I was always reacting to what was coming. You have a request, and you just sort of figure it out, and that was your training.

This baptism-by-fire feeling is common in public health, quite possibly in part because public health agencies do not yet understand socialization processes and the impact of more effective orientation programs.

It should be noted that a few groundbreaking initiatives are occurring in this region, as was told to me in a few different interviews. One was a public health nurse residency program that had been in the planning stage and was to be initiated after my interviews were completed. This program was to include monthly presentations or trainings by various regional content experts for the mission of understanding other local public health agencies and bigger picture public health operations. The other initiative involves several Communities of Practice (CoP) groups surrounding various roles (e.g. nurses, environmental, educators) that are attempting to regularly meet and share best practice ideas as well as networking across the region. Given that I could not garner

more data on these initiatives, I cannot speak to their effectiveness or impact beyond what participants shared with me about these efforts, which was minimal.

Length too short. Although there were not set parameters for the length of these participants' socialization or orientation, the initial push to train seemed to wane within the first three months when regular meetings with their supervisors tapered off. Some people felt comfortable and felt like more of a public health professional between 6 months and 1 year. But others still felt uncertain after even 2 and 3 years. Sherron's supervisor told her it would take 3 to 5 years to grasp public health. Anna's supervisor suggested:

> Orientation takes about a year, and I think it's longer. Maybe it's because of not coming from a previous background [in public health]. Even just the simple things, like I never used the word municipality or jurisdiction or stuff like that.

While a few of the participants felt more comfortable in their role after 6 months, the majority did not feel comfortable until well after one full year and typically closer to two full years. Tami, on the lower end of the socialization length spectrum, noted that somewhere between 6 months and a year, "I felt like I got to the point where I knew more than I didn't know—which included knowing things I could do to fill my time, and what was mine, and where I contributed." In the middle was Kalea, who stated:

> I think it probably took me about a year and a half before I really felt like I had any idea about what was going on, and I wasn't just constantly flailing, and I knew that I wasn't [because] at that point, I had had a whole year of a grant period down. . . . I knew that I didn't fail it, which helped, so I started to feel more confident.

On the other end of the spectrum was Dee, who has worked in public health for 3 ½ years. She said, “I don't even know if I'm at that point now, especially working with the people I work with who have been in public health for 20-some odd years. I still feel like the new kid.” Having employees who still feel uncomfortable or like an outsider after several years of employment points to the need for extending the length of socialization for new public health employees until they express feeling more comfortable.

Forced resourcefulness. The importance of socialization lies in how new employees interact with any socialization that is provided and relate it to themselves. Weiss (1978) found that those with higher self-esteem use their own judgment in new career situations and rely less on role models. Newcomers who possess the traits of self-efficacy will tend to be more autonomous in organizational situations even when their roles are prescribed (Jones, 1986); they respond to situations in their own terms. Because the majority of the participants described their first days or weeks as overwhelming, it was interesting to see so many of these participants utilizing proactive behaviors to reduce uncertainty by resourcefully seeking information and asking questions. While some research has claimed that new employees are active participants in the socialization process instead of relying on the organization to provide everything (Ashford & Black, 1996; Morrison, 1993), these new public health employees’ active participation far exceeded a level that they felt comfortable with in those early days and months.

Instead of waiting for their organization, each of these participants became quite resourceful in “filling in” the holes in the socialization that their supervisors and organizations did not provide for. Examples of resourcefulness included several of the

participants using Google to figure out the answers to questions from the public or to find resources for a project they had been given. Chelsea used Google to find management and other training as an effort to fill the void in her socialization. In addition, Chelsea recalls:

> It's like you're the only one here who can do this, so figure it out! I really had to learn quick by calling people at the state [health department] and calling other resources. . . . I was calling people and saying, 'Hey, teach me about this—I want to learn about this.' So I got very comfortable with finding resources and learning stuff that way, because that's kind of what happened.

Tami adds that her keys to success are, “Persistence—not being afraid to ask questions. The big thing is just keep asking questions, and if you're not getting the answer that you are looking for, find someone else.” Chelsea made this comment about what she did when she was new and observing co-workers:

> I think they were receptive because it wasn't like I just sat there and observed them. I asked questions. Like when they were done interviewing a patient for a communicable disease, [I'd ask] why did you ask this question? [Their answer] led me to this so I asked more questions. I didn't just sit back—I actually asked questions like 'How did you learn this?' 'Where did you get this from?' 'Where'd you get that information?' I asked a lot of questions.

George had a supportive supervisor whom he met with daily:

> I'd have him down there all the time. He was very helpful; he answered my questions. Like I said, I asked a lot of questions: what do I do here, what do I do there? I'm a questioning guy because I want to make sure.

Katy discovered some push back when she tried to be resourceful and ask many questions:

> I need to make sure that I am well informed that I'm doing the best I can so that I can give the best. . . . I'll walk right through the elephant, I refuse to go around it. Sometimes I can be offensive to people, because in our department, the culture is almost like a child, should be seen and not heard . . . and I'm not with that.

Kailey found that experienced workers were sometimes frustrated with her level of questioning:

> I remember someone saying, 'Okay, you come over here and you highlight the vaccine they are going to get with a yellow highlighter.' And I guess I felt like I was constantly saying 'why.' Why does it have to be *that* highlighter?' 'Well, that's because we've always done it that way.' And that was really hard to get over. I felt [annoying] sometimes and accept it a little bit more, but I am constantly saying, why do they do it that way? Because I needed to know. I needed to see that end to know the significance of doing it now.

Due to the lack of formal and consistent socialization, direction, and feedback, newcomers to public health feel an expectation to "'just figure it out" and find resources on their own. This led to a feeling of frustration in some or a challenge in others. Much of this may depend on how supportive the supervisor and co-workers are to answering many questions. Even with asking many questions, people were still not comfortable, nor did they feel that their knowledge base was as deep as it should be without other aspects of socialization occurring in tandem.

Lack of academic preparation. While this topic deviates from socialization that occurs during a public health professional career, it was necessary to include it due to the amount of feedback received from participants about academia being remiss in teaching students that public health is a career path and what it entails. Most of the participants did not come from a public health background. Many came from supporting backgrounds such as nursing, nutrition, biology, social work, and epidemiology. Most participants reported that their academic careers did not prepare them for their work in public health. "A difficulty with using socialization as a model for professional identity formation is that students' expectations may not be met and this may result in the student feeling out of place within the system" (Johnson et al., 2012, p. 564).

With many theories and research that find that socialization and professional identity development begin during one's education, the following comments show how that is not true for these participants—there was a definite lack of it during these participants' education. For example, Chelsea noted:

> I never really learned about what actually public health is [in school]. You hear about what public health is, but it's really not like what *actually* public health is. There's a really big disconnect between what public health is and what they teach you in school.

She suggests having schools talk about various public health roles instead of just about public health nurses and environmentalists, to teach about specialists/educators, to build a foundation. She tells interns in her department the following:

> We try to tell them you're going to be at a computer. You're going to be trying to plan programs. I try to warn people—like I do a lot of nursing over the phone.

> They don't really get it like how much they're going to be sitting in front of a computer or planning educational stuff. It takes a while to plan an educational session.

Anna summed up the extent of her public health portion in her education career as:

> I remember doing an epidemiology unit, and I spent a couple weeks on that. The big thing that we did for our public health unit was we went to a long-term care facility. . . . We did some practice doing physical assessments. We were all assigned a topic at one point during the semester to provide community presentations. It really felt most like a blood pressure screening clinic, because we always checked blood pressures. I really didn't get much out of it.

Tami added:

> Schools don't know what they do! You need to have the people who are teaching public health who have done public health, and they don't! It is ridiculous to me that [so many public health professors] have never done it.

She admitted that she taught a masters-level public health course for years in a home rule state without knowing that it was a home rule state or what that even meant. But Tami did say that her education gave her:

> . . . the ability to present my ideas, the importance of connections. I really think that for the most part, that was the most beneficial thing . . . and the ability to write at a level for the public as opposed to scientific writing.

JJ mentioned:

> They kind of told us in college, once you graduate and go into nursing, you are going to be disappointed that it's not what you thought it would be. That did end

> up being true. I had this grand idea of public health being more community based and not just sitting in a cubicle.

Brittney made a suggestion about the biggest thing needed to recruit and retain talent to public health:

> I think the biggest part as far as getting it in college either a semester or a full rotation in public health. Most students coming in don't have a clue what goes on. . . .You need that critical thinking and knowing where the resources are and where to go.

Anna suggested that nursing programs reintroduce public health during their senior year. Sue suggested more internships in public health: “You never know what kind of pipeline public health interests or awareness you can build just by [assisting] an intern.” Stacy said she may have declared a different undergraduate degree had she known about public health then.

Kalea felt her academic coursework portrayed public health more successfully than others. She heard a dynamic, well-known advocate and professor of public health speak several times in a general health care course of hers:

> So I think I was set up, in a way, to really like public health because I had someone who was so influential in the program come in and speak during this general class. And he's good at convincing you to like something, for one! But I got a really honest opinion about what public health is.

The data about lack of academic training regarding careers in public health should spur not only more research into this subject but can point out action steps that nursing,

education, and other public health support programs could take to change direction and guide students to the field of public health.

Theme 2: Programmatic and Hierarchical Isolation

The majority of participants discussed concerns about feeling isolated from colleagues, especially those in other parts of the agency, and several felt isolated from their agency's leadership. Some, without even knowing what they were missing, seemed lost without a strong social support system. They knew that there were gaps in their knowledge about the whole of public health but were not always sure of what was missing. I noticed a lot of uncertainty in answers and little clarity.

Lack of support systems. Only two-thirds of participants had experienced either a mentor or peer group or both. Four described having a peer group they could trust, rely on, vent to, and learn from, but no mentor. Four additional people claimed that they had both a mentor and a peer group in their first year. Of these four, not one stated that they saw themselves in public health definitively in five years. All four claimed to be insiders to public health, but this level of socialization support did not seem to impact their future potential retention in contrast with research claims (Bauer et al., 2007). Regardless, participants' comments showed the importance of having support of a mentor, a peer group, or both.

Boss as "mentor." Four participants discussed having had a mentor but no peer group, even though their definition of mentor was not congruent with academic definitions of mentor and fell short of the definition of a true, long-term mentor. What many of the participants experienced should be defined more as a coach than a mentor in that the person was often a boss who guided the newcomers more on performance

and successful task completion, focused on a specific agenda that comes with the job. A mentor comes with no specific agenda and is more focused on developing the individual.

Kailey has a supportive boss whom she considers a peer mentor because she sees him more as a peer than a supervisor. He showed her the big picture by including her in various meetings and partner groups. Tami would consider her boss the best mentor she has had in public health because of the “sheer volume of things I have learned from her especially at a public health level and being able to approach her and ask questions.” Her boss has asked her where she wants to be in five years and seeks to get her to that point. Chelsea’s first supervisor was similar in that her goal was to get her “to go on to do bigger and better things.” Chelsea stated that her supervisor would say, “I am a good supervisor if I can get you to the point where you go on to be a supervisor.”

Carson had a couple of mentors from a previous, non-public health career that:

> . . . taught me a lot more than any school would have taught me, and that's probably part of the reason why I'm so good at what I do because they taught me how to dig into a mess and figure it out.

Stephanie’s boss guided her in an attempt to transition into his job upon retirement by including her in meetings with his boss and through discussions about career goals and what was happening at higher levels. "That's part of the reason I have stayed here as long as I have is because I had that mentorship," Stephanie reported.

When asked what it would take to recruit and retain talent to the field, six people mentioned that having a mentorship program would be helpful. Kailey summed it up by

claiming a need for an encouraging “cheerleader” telling you that “what we do is awesome” and "to get you excited about what you do and make you fall in love with your practice and have it be more than just a job.”

Deficient leadership. The leadership of a public health agency plays a vital part in how new employees are welcomed and socialized, not only into their agency but into the field of public health. The leadership of a department can affect how connections are made and how the overall big picture is conveyed.

Tami feels that even though her supervisor has been a good mentor, she is missing a link in learning how to be a leader and understanding why certain decisions are made. She said, “That's another thing that hopefully [my supervisor] will teach me is how to lead, because there are things that I will do, and she'll be like, ‘Well, were going to do this.’ And I’m not sure why.”

Sheridan thinks that leadership is not always what could be most suitable:

> I think one of the key things for me too with leadership is hiring people who are actually qualified to do the job. Not just hiring your buddy that you met years ago that you’re close to. One thing that I think about is that my position requires a master's degree, but yet my supervisor doesn't have a master's, [and their supervisor] doesn't have a master's. [In all of our leadership], only one person has an MPH, so when you think about the future and who's making these decisions, they're not trained in public health . . . How do we change the culture here when our leadership is what it is?

Sheridan gave an example:

We have a certain group that's working on it, but to a certain extent, it doesn't seem like there's always as much buy-in from the leadership at the top. Like many of our staff don't even know what we're doing [with our Community Health Improvement Planning]. They don't know what it is; our upper management can't even explain it as well as they should be able to, and just not feeling the support, or you hear negative reactions from them like 'Why do I have to be here', or when they are there it seems like they're complaining that they're there, or they're on their phone the entire time.

Stacy describes how her agency's leadership does not have a requirement to have had a public health degree or background:

I feel like our upper administration doesn't have the public health mindset—I feel like a lot of their decisions are too political, so that's kind of disheartening to me you know, to have upper management who ultimately [has lost public health perspective]. I feel like I still have it, but I feel like they don't, and it's kind of an issue.

Stacy gave an example of having never met the highest health administrator formally in the several years that she has been employed there. "What's really important is the culture that's created by upper management because it trickles down certainly. I think getting them involved in the process, too."

Importance of peers. In this research, those who had peer groups supporting them enthusiastically spoke of how their peers have aided their careers. A few without a peer group lamented that they wished they had peers, but most without a peer group

did not even realize what that type of support could provide as they had not experienced it.

Tami noted that social events like going out to dinner or networking socials are lacking: "They are where some of the best things happen, and I don't see that in local public health.” She developed her own peer group through:

> . . . being able to have a friendly face or someone to sit next to [at meetings, who] kind of got me to stick with it . . . having the ability to reach out to them and ask them stupid questions. One of the most valuable things that I got from them, I think, was how their [public health program] crosses over into all the other areas.

She claimed that she learns the most from classmates in school and from peers in her career. “I think that those meetings where you're meeting with other people in the same position from other departments are invaluable.” Brittney had a cubicle mate who became her best friend:

> Just having that person to share stories with really made a big difference in that job initially . . . keeping me there partly and just having that reassurance that I had someone to go to when I didn’t know what I was doing. Not that I couldn’t have found someone else, but it was nice having someone that I knew really well or connected with. I think it would be a lot more stressful not being able to vent to someone who gives advice and feedback, keep a level head, or at least understand what's going on.”

Stacy has peers to go to for different needs: "That has been huge, especially early on with [a difficult work situation] and being able to bounce stuff off of them. That was really important.”

James had a de facto mentor in a peer who did most of his early training, which resulted in peers he can vent to at lunch or in the break room. He has trust in them because “everyone has the same gripes” and they have fun together. Sue attends a monthly meeting of all [people in a similar role] where their trusting relationship allows them to bounce ideas around. This meeting was coordinated by those higher up, which she is grateful for, because she might not even know these people without such coordination:

> They have helped me survive the most stressful parts [of my job] . . . I think I would feel incredibly alone because I am the only [role like me] in our department, and if I didn’t have people that I could bounce ideas off of or people saying ‘You know what, that’s not your job. You shouldn’t be taking that on.’

Sheridan counts on and trusts the same-age peers in her [building] whom she can vent to for stress relief and encouragement: “They've been a great support to me. I think they've made me enjoy my job more.” Stephanie said her monthly meeting of peer managers was helpful for having a support system and that they became friends outside of work, adding that supervising was "an isolating position to be in, and until I had that group, I felt like I didn’t have a peer.”

Kalea has this to say about peer groups: “So that is a huge aspect of making you want to stay with your organization, too, is feeling like you have more than just colleagues.” She attends regional quarterly meetings of others in similar roles to share best practices and network. These meetings are held at different departments or restaurants to build awareness of others’ departments and programs. Kalea said, “It's helped me entirely because you don't have to reinvent the wheel. You have people you

can go to for resources that I didn’t know existed before," but it hasn’t moved beyond professional meetings. “I would say it's probably taken my whole 3 years to get there—to feel comfortable with these people and I can call and say 'Oh my gosh, this is ridiculous' and just vent about stuff.” Kalea also added, “You have a meeting and stay 45 minutes after just chatting with people, and that's twice as valuable than the educational session . . . the amount of stuff that I learn after.”

Networking opportunities. A few participants had good colleague experiences but not the trust-building peer groups. Dee sat with neighboring health departments to get to know them and form a community of workers. Sherron stated that she finally felt a good team concept once her current supervisor and new public health educator were hired (3 years after her hire), as she started to feel more comfortable because of the great camaraderie: "That is when I started going . . . this is good.” Katy, who had a differing view, believes a program of hers was taken away because she didn’t rub elbows enough, although she wishes that she had peers she could trust. “I swear there's people in this building that I’ve never met. I'm not joking!”

It should be noted that the state public health department hosts a one-day orientation for new public health employees that includes topics from data systems and funding to history and laboratory functions. It is held every spring and fall. Only eight of the participants had attended it; others were not even made aware of it, or it fell on a day that they could not attend. None of the participants from the state’s largest local health department had attended it. All eight of the participants who attended stated that they attended too far into their career, when the information was not as useful. Most stated that it would be more beneficial to attend this orientation between their third and

fifth month of employment in public health but not later, when the information presented became less relevant.

They also felt that if they went during their first 2 months, they were too overwhelmed to retain anything. Participants also mentioned that they wished there were many more opportunities for networking and sharing at this orientation. Funding issues “often preclude offering [orientations] with the frequency needed for them to be timely for all new hires” (Klein & Weaver, 2000, p. 62), but this is an area that the state health department could reassess. Kailey added, “I felt like some of it was a little bit dated and didn't work with adult learning styles. As a very visual learner, I felt like I just needed more.”

Broader image missing. When initially asking about what socialization or orientation tactics each participant had, their answers almost always centered on trainings, whether they received instruction from or observed a co-worker, or were given a list of videos to watch. Given that socialization is much broader, I found that I had to prompt with additional questions such as asking if participants had a mentor or a peer group, asking if they had any grant versus tax levy (financial) training or any political training, such as how the city council or board of health operates.

This prompting on the bigger picture and the broader aspects of socialization may have brought the validity of the research into question, but as a phenomenologist, I do not think I would have achieved depth of the lived experience without asking such questions in this particular instance. In listening to what the participants did not say, it was apparent that they did not know what they did not know. This furthered the conclusion that public health leaders need to guide the depth and breadth of a new

employee’s knowledge base because they likely did not receive that big picture in their academic career.

A few participants felt they received the bigger picture from a supportive boss or a fellowship mentor. One saw the bigger picture when working on a communicable disease case with the state health department and the Centers for Disease Control and Prevention (CDC). But most were lacking on several aspects of the “bigger picture” given that no one guided their training and understanding toward this. Jordan received the bigger picture after returning to a master of public health (MPH) program several years into his career: “You kind of get focused on one thing [in the job role] whereas in the class you’re like ‘Holy Cow! Public health is everywhere!’” For Brittney, it was clear that the reason for moving from a role in a large health department to a smaller health department job was to understand public health better. She said, "It kind of opened my eyes to the world of public health and what it truly is. It’s amazing all of the different other connections." She felt that it took longer to learn everything at the larger health department whereas at the smaller one, it took only a couple of months.

Strategic plans. A factor that was found to significantly and positively correlate to governmental employees deciding to remain with their current employer included identifying with the organization’s mission (Yeager et al., 2016). Yet knowledge of their organization’s mission, vision, and strategic plan was lacking for most of these 18 participants. Katy was never told what the agency priorities were: "I feel like I don’t have a reference base for anything." And she wished she had someone to give her the:

> . . . real scope as to what the job looks like. What the day-to-day in this job is like, how to access—there was no directory. We toured the buildings but how you

impact the flow, how accounting plays a role, and if my position is grant funded, what does that mean for me long term?

Anna described missing the bigger picture:

> I could tell that some of the more seasoned nurses thought I was kind of naive because I really didn't know what I was doing for a lot of it. Like we had our quality improvement groups, and I really didn't know what the whole goal was. So I had my assignment, but I felt like I totally missed the mark.

Anna also described a case management situation where the nurses just handed over a spreadsheet and said to call them:

> The whole case management was new to me. I just didn’t know. I just really didn't understand how to get them done. I had been calling and calling one new mom when finally I received an answer of ’please stop calling . . . she gave the baby up for adoption.’ That was a rude awakening. I guess it would have been nice to have some coaching or a go-to person when it comes to case management. It was kind of like learning by fire.

Sue stated, “I wish I had a better sense of the . . . strategy internally, to teach people about who we are, what we do and why, and how it’s all connected because were very siloed.” Sue also discussed an underlying concern that a few others brought up: a desire to discuss, obtain knowledge, and solidify how the future of public health may look very different:

> Public health is changing from being the direct services to the bigger issues like health equity, so not only are we trying to build knowledge internally, what that means addressing health equity . . . but build that awareness out in the

> community as we build things like our Community Health Improvement Plan. I've been learning a lot along the way about what that means and looking at other examples from other communities and how they are communicating that. I think the challenge has been that there is no clear direction as to where—we have our priority issues, but to get there is this whole mess of what you need to address. We're trying to build a clear path so that people outside can understand that, but we're still figuring it out internally—what it means to address that. It's a challenge to really understand.

Sue added that most in public health know what needs to be impacted, but the issue is how they can really impact it in the environment they work in along with dealing with the need for direct services within the community.

Political and financial. Regarding the political and government structure, Anna stated that having more interaction with the board of health (BOH) and city council, and knowing grants "would be helpful." Dee felt that she should have gone to BOH and council meetings to pick up on the fiscal and governmental narrative sooner:

> I think maybe getting a little more education about the government aspect of it and how your ordinances play a part into it as well as your state statutes, because that was all a learning curve for me. So maybe that being presented first off would have been good. Maybe it was and I didn't realize how it would impact me at the time, so I overlooked it.

Sue added:

> I think the education that I didn't get and am still learning [after 5 years in her position] is more about city government and the policies and procedures. I think that kind of onboarding is lacking in terms of overall city government.

Chelsea said she keeps hoping and asking to get information on the financial and budgeting system. Similarly, Jordan received no financial or political training, but he does not feel that that is really needed because [his division] makes its own revenue. Stephanie learned financial aspects via trial and error: “Some of it is trial and error—you do something wrong, and then somebody's like, are you sure that's how you're supposed to do that?”

During a recent master’s degree program, Kalea was taking classes in finance and accounting. Because of these classes, her boss pulled her in to work on their city budget, and “that helped a lot because I really didn't understand it much before.” She feels that having financial training early on would have helped tremendously. She continues to advocate for financial training often:

> I think that open communication in regards to financing of a department is incredibly valuable and never utilized. . . . I should know the budget for the programs that I am working on, and how that budget is being used. . . . If I'm doing all of the work for that grant, in my opinion, I should know what that grant money is being used for. I don't need to have a say on it, but just to get the whole picture of my job I think I kind of need to know what's going on. And I think as an employee I should know how I am getting funded especially working in government. It's important and we're really not included in that. . . . When we

> were feeling as a staff very discouraged about why we can't spend money on certain areas . . . and instead of like feeling discouraged if we would have had that open communication to be able to look at the budget. We only have this much money budgeted for training and staff development, this one is budgeted for advertising and supplies. We were asking why we can't buy stuff like giveaways for the health fair. If I had of known what the budget was, I think that would have really helped with staff morale, and feeling like you are being heard as an employee and understanding what it means to work for a government.

Silos. The term “silo” has been common in public health-speak for many years. Here in the United States, “Public health is silo-driven without a unified consistent identity” (Kaufman et al., 2014, p. 563). So I was not surprised to hear participants vocalizing concerns over the issue of programs or departments not communicating with each other, as if separated by walls within the same department. This was not exclusive to larger health departments. Kalea mentioned her smaller health department, “We're very siloed. The public health nurses did nursing duties only. The environmental staff did their work only.” Chelsea said that on her first day, she was told not to walk down a certain hallway because that’s where the Woman, Infants, and Children (WIC) program was located, in an assumption that she did not need to know about WIC because she would not be directly working with WIC. Sue wishes that her agency conveyed the overall strategic plan better internally:

> . . . to teach people about who we are, what we do and why, and how it's all connected, because we're very siloed. People are very focused, like someone in our lead program every day for 40 plus hours a week is focused on lead, but do

> they understand how that connects to our priority health issues? I don't know if they could say that.

She continued with, “We don't have a lot of opportunities for people who don't work together on a daily basis to actually interact, and I think that's why we've stayed so siloed. And people are at different locations.” Brittney added that silos existed at a larger health department:

> It would have helped to have time to learn about general public health. It's great we got hired for a job to do that job, but within the first year that you're there, [it would be helpful to] learn about the different positions that you could transfer into. Because again, I had no idea about what the other divisions were, what they did, how they worked. It would have been nice to know how that all worked together especially working with moms. If you need to make referrals or are getting calls from somebody else about other diseases, just knowing who to make those connections with.

Sheridan has ideas on breaking down the silos internal to her agency:

> I think being able to interact more with people who have so many years of experience and learning from them. Especially because there's some people here who their interests are so broad and there's so much you can learn from them and they can think big picture—they're not so siloed on their individual work. So I think more opportunity to interact with them. Being involved in their meetings or any work that they're doing would be very helpful.

Silos can occur within an agency but can also occur between local public health departments. Kailey is one of a few people working to increase communication between

agencies. She spearheaded a workgroup “to start breaking down some of those silos and getting people to work together and share ideas and collaborate more” across the region.

Cross-training desired. As part of learning the bigger picture, several participants reported that they were never cross-trained and felt that such training would have helped in their greater understanding of public health. Stacy wished that she had been given a better layout of the health department and an overview of different programs; “I think getting people to know people in other programs is super important and also a way to make friends across programs, too,” she said. James received no cross-training and had the unfortunate experience of being reprimanded when asking to cross-train:

> I wanted to learn some of [my colleagues’ jobs] so if people go on vacation or were sick or whatever. Again, I was discouraged. They want you to focus on your stuff. . . . I want to learn how to do more stuff so I can be a better employee and expand my repertoire as a public health worker.

Kailey gave a similar example of where she felt like she was forced to pass the buck:

> Even though we all are generalists, I feel like a lot of the nurses that I work with have their specialty and want to keep it that way. . . .When I was new and someone would call, I would want to help them, but we have a mentality in our office where . . . "Well, you just send that call to me – I'll take care of that because that's my domain.” Whereas I want to be able to help everyone and have those answers, so I think that's also sort of a challenge and why I still don't feel completely comfortable with answering those calls.

Anna wished she knew more about how the different health departments in her geographic region were structured because they have to communicate often. She stated, “I still don't get [these other health departments], and it's very frustrating. And it's very frustrating for them, too.”

Many of the participants noted instances where the long-term public health employees were resistant to newer technology, and a lack of sharing or cross-training in general.

Sherron mentioned the territorial issue:

> I think too getting a lot of these programs out in the community and having community involvement is so much better than being the only one doing it all. The older nurses say ‘that’s mine.’ There was a lot of ownership issues, and even to this day there’s like ownership going on. We are only part time, and we cannot do it all. I think since we are turning over people, there is more of a team concept.

JJ detailed his experience with the territorialism and lack of cross-training issues:

> You could tell there was frustration with [the newcomers] because it was older staff who were all specialized, and they didn't want to give up their program and let us work on it, so we were just kind of sitting there. We were almost like auxiliary public health nurses that if they need us to help with the line list or with a flu shot, they could have us do something.

A few participants agreed that this mentality appears to be moving out as some retire and staff changes occur.

Theme 3: Tenuous Professional Identity

This research found that a commitment to public service was indeed a driving factor in deciding to work for public health and in what provides job satisfaction. It also found that a lack of this can leave a lack of commitment to the profession.

False prior expectations = later satisfaction. A newcomer may be quite surprised that what they expected as an ideal professional is different from reality once entering their career, thus affecting their perception of professional identity (Melia, 1981, 1984). Many of the participants had little to no prior expectations before arriving into their position, as summed up best by Chelsea, who said, “I had no clue” and Brittney, who had “zero expectations.” As found in other studies, new employees “find themselves giving up some expectations of the professional role to which they were socialized in order to function as professional employees” (Lurie, 1981).

But among the few expectations participants had was that they would be doing a lot of work with community, as reflected in Tami’s and Dee’s comments respectively, “I’m not sure I knew an awful lot about what public health would entail. Thought it would be a lot more direct contact with the community”; and “I thought it would be a lot of working with the community and getting out in the community to get messages out”; and Sheridan’s words, “I just thought it was all about helping people be their best selves as far as their health is concerned.” Kalea felt similarly, specifying that she thought that it would include “direct educational presentations, building partnerships with local businesses and organizations, but I didn’t think about the amount of time for quality improvement, performance management, and the people that are not out in the community that work internally.”

Toward the end of the interview, I asked what about their jobs provides the most satisfaction, and found that most of the participants felt satisfaction when making a difference with community members. Kailey spoke of watching high school students grow because of her programming, which made her “feel needed and making a difference.” Jordan summed it up by saying, “When people take a training to heart and you get a thank you or a validation for what you’ve done . . . finding people that are excited about it.” Carson, who rarely has the opportunity to work with the community because of his role, gave this example: “I like when I go to [health fairs] and see the people we are helping.” And Katy’s response, “I love the opportunities we can put a better spin on what’s happening in our community and getting people to buy into public health; being out in the community and helping people with basic needs and providing rationale.”

The disconnect of people expecting to be doing a great deal of work in the community and then doing very little of that once their role gets going can have an impact on their retention within the field. New employees find that there is a lot of administrative work, meeting contractual goals, and plan writing, and less emphasis on client care or changing public health behaviors (Pearcey & Draper, 2008). This could be due to their incorrect prior assumptions of public health work and/or public health leaders and academic programs not clearly defining the work of public health to them. The Institutes of Medicine (1988) definition is broad in that it does not proclaim that all public health workers will be working out in the community nor interacting directly with individuals but *assisting* in creating the conditions that lead to health: “what we as a society do collectively to assure the conditions in which people can be healthy (p. 1).

Yet this prior expectation is still what provides the most satisfaction for many of the participants. Leadership within public health can work to link their employees to community members in order to provide more opportunities for employee satisfaction, as public health by its very nature is a direct social action. In addition, helping employees to know and understand the widely accepted IOM definition of public health can assist in correcting expectations and formation of an accepted public health professional identity.

Insider or outsider status. Not everyone felt like an insider in the public health field, even after several years of working in their agency. Most answers were lukewarm, with participants not willing to outwardly commit to saying that they identified themselves with the profession of public health. Kailey felt that she was closer to becoming an insider but has not aligned "to the degree that I felt connected to [my previous career]." She felt more comfortable at the 1-year mark when she:

> . . . really started to get to know people and know the names when people were talking about other health departments helped. And I think just also getting comfortable with the people you work with and fitting into their norms and comfortable with myself, I guess.

She also added, “We all did go out once for dinner and drinks one night, which was helpful to get to know people on a personal level more.”

Sherron feels similarly: “I feel like I am confident. Am I overconfident? Absolutely not. Am I hesitant about a lot of stuff still? Yes." She only feels part of the public health profession “some days. For the most part, I still have a hard time explaining to people

what the public health profession does," which increases her feelings of not feeling valued by those outside of public health and in political positions.

JJ's insider status lies in the unsure word "probably", due to getting to know others in other health departments. "I don't think I'm an insider but certainly maybe in the breezeway." He feels that having a public health certification would help his feelings of being an insider. Tami reached a point:

> . . . somewhere between 6 months and a year, I felt like I got to the point where I knew more than I didn't know—which included knowing things I could do to fill my time, and what was mine, and where I contributed.

Tami equates this point as "being at the level to ask good questions" from the point of not even knowing what questions to ask. On the topic of her identity, Tami said, "I feel like my identity revolves around being able to find the source and also distill it to a point that's understandable by others," a marriage of skills and abilities with knowledge.

Jordan said in reference to how long before he was comfortable, "I think it took a good year—you're kind of developing as you go before you have any real valid input, I guess." Brittney definitely feels an insider status now, 1 to 2 years after moving from a specialist position to a generalist position. "Not that I was an outsider, but I definitely feel more connected now," having partnerships with people and making connections outside of the health department.

Sheridan agreed that it took making connections and becoming a part of the bigger picture to feel like an insider. "I'm very involved in the work of all of our programs, even across different divisions." But this only occurred after her supervisor left:

I guess I realized how much she shielded me from different things or opportunities. I got to sort of step outside my usual role when she left because I took on a lot of responsibilities that she had . . . that's definitely when I began to feel more involved in the work that we do here at the health department.

Kalea had a similar comment:

I think it probably took me about a year and a half [after moving to a more generalist role from a specialist role in public health] before I really felt like I had any idea about what was going on, and I wasn't just constantly flailing and I knew that I wasn't. . . . It happens from getting out of the office through going to conferences where I've gotten to know people, go to these community meetings with other people, and getting to know other aspects of [public health] . . . and obviously building up local partners . . . when I started to feel like 'okay I'm here people know me. I know people. We are one in the same.'

Stephanie agrees that she did not feel like an insider until meeting neighboring health departments and collaborating on projects with them.

Conversely, Carson stated:

I guess as far as the public health profession goes, I don't know if I really feel like I'm an inside member because again, I don't go to any of these meetings or committees or anything like that, but again, it doesn't really apply to me. I am more of a support role.

Similarly, Sue stated, "I don't think I see myself as a public health worker, but I do see myself as part of the public health team." She clarified that this is because her background was not in public health and because her training and role fall mainly in a

complimentary field. Katy, when questioned on if she felt like an insider to public health, said, “I don’t even know what that transition would look like." Dee furthers this thought:

> I don't know, I don't even know if I'm at that point now especially working with the people I work with who have been in public health for 20-some odd years. I still feel like the new kid. I don't know it all yet, not that I ever will!

Feelings of impostership. For a new employee, having to be highly proactive in their own socialization and at the start of their new role can lead to feelings of impostership. If agencies set the bar too high, expecting new employees to be productive long before they are ready, it can lead to feelings of non-accomplishment, intellectual fraud, guilt about success, and impostership, even though employees are still able to fulfill their work requirements (Sakulku & Alexander, 2011; Webster-Wright, 2006).

Jordan describes his sense of impostership:

> As a coordinator, I get calls and emails all day long people asking me questions, ‘can I do this, can I do that?’ They see me as a wealth of knowledge. How I see myself? I think I'm still learning—you know, you learn something every day. In some things, I know I definitely have a ways to go.”

Sue’s feeling of impostership has led her to not feel like a true public health professional:

> When I go in meetings and stuff, I introduce myself as the [job title] for the health department. People expect me to know what we're doing. I represent the health department then, not just [my role]. I think that's the experience I get the most often is representing the [city] health department and not just [my role]. That’s the

way I have to speak and actually have to try to encourage our internal staff to represent themselves. They don't just represent one program or department, they are a representative of us, our agency.

Anna lamented:

> I like that we're a small health department because it's kind of frustrating to feel like I'm not an expert on anything. As an example, two weeks ago I was at a lead meeting, and [another agency's employee] was walking out and she was chatting and she asked me about what programs I do and . . . 'Oh, you do PNCC' and . . . I should know that, you know what I mean? So that kind of made me feel more like oh crap, but I don't do a ton I guess I don't . . . some people have their specialties, and I shouldn't, and I kind of feel like sometimes I'm kind of like skating on the surface . . . you're trying to keep up with so many possible areas.

Because of situations like this, Anna said, "I don't really think of myself as successful." She added that the only keys to her success are her co-workers' "patience with my stupidity sometimes" and feeling free to ask "stupid" questions.

It was apparent in the comments of participants that even if they were proactive in asking questions, seeking others to observe, and finding resources, they still felt like an imposter or that they were an intellectual fraud in the field of public health. I wondered if this could be a cultural issue, although it has been found to affect nearly 58% of men and 80% of women professionals and students no matter the career path (Matthews & Clance, 1985). Still, this is not to excuse public health from doing more to lessen feelings of impostership among its newcomers. There was no perceivable difference among gender and impostership in these 18 participants.

Professional memberships lacking. Only two (11%) of the participants belong to their state public health association. These two sought it out on their own: they were not told about it by their agency staff, nor did the association approach them. A few others have gone to the state's annual public health conference because their agency was a member of the state public health association. Very few participants hold licenses unless specifically necessary for their roles (e.g., registered sanitarian). Only one had heard of the Certified in Public Health (CPH) credential for public health leaders by the National Board of Public Health Examiners. Within this participant pool, there are very few ties to national or state organizations that can provide a sense of belonging.

Dee does not think that a national credentialing system would be beneficial to the field of public health "because it still doesn't help the general public," meaning that employees having added credentials does not help the public to understand the field any better. Yet upon hearing of the national certification in public health, Tami thinks that it could legitimize the profession and help hold schools to a higher standard as well. JJ agrees that having professional certification would help public health professionals feel more like insiders. Similarly, Kailey stated, "I think certifications help you embrace who we are in the profession." Chelsea is quick to point out that most certifications are cost prohibitive. Yet even with an increase in public health employees becoming members in various active organizations, the invisibility of the profession with the general public (P. Crawford, et al., 2008; McCrae et al., 2014) is an external threat to professional identity-building.

Conclusion

This research was based on the narrations of 18 public health employees reflecting on their socialization experiences and how they perceive themselves to have a professional identity, or not. The common characteristics that emerged from a review of the data led to a strong universal and "composite description of the phenomenon incorporating both the textural and structural descriptions . . . [known as the] essence of the experience" (Creswell, 2007, p.159). It also led to three clear themes. The first theme is that socialization within public health is overwhelming and piecemeal at best with being thrown in to figure it out on one's own, forcing a movement of resourcefulness that need not exist in its current state. Lack of socialization coupled with programmatic and hierarchical isolation leads to a tenuous public health professional identity where new employees do not feel as insiders and their expectations of working in the community are not met. The following chapter discusses these themes in terms of how they can impact the field of public health alongside actionable steps that can be readily implemented such as cross-training, education on the bigger picture of public health (e.g. political, financial, strategic plans), and offering stronger support systems.

Chapter 5: Discussion, Implications, and Conclusion

Three themes and seven subthemes emerged from the data, each addressing the three research questions. The themes and subthemes are displayed in the following visual, which shows how a socialization that is not thorough, combined with isolation, leave a public health employee's professional identity in a fragile state, where it can be swayed either further into the field of public health or blown away from public health:

Figure 5.1. Missing Socialization Leaves Tenuous Professional Identity in the Breezeway

Figure 5.1 shows how the current unplanned and sporadic levels of socialization coupled with program isolation and lack of social support and leadership (the two themes in the clouds) lead to a very loose professional identity in the field of public health. This lukewarm professional identity has newer employees standing in the breezeway and on the cusp of making a decision: on whether to open the door ahead of them and fully commit to the field of public health, go back to their former career or whatever they were academically training in (the door behind them), or be blown through the breezeway in another career direction that has little to do with public health. This visual represents the gravity of the situation that the public health workforce faces if leadership does not assist new employees in their socialization processes and in building a public health professional identity, strategically guiding them through the door in front of them.

This study explored the relationship between public health professional socialization and the formation of a public health professional identity. The primary aim of this final chapter is to explain the findings of this study relative to the three research questions and to explain their relationship to the literature. I also discuss the limitations of this study and its implications for the practice field of public health, education, and research. Finally, I offer suggestions for future research that might provide further insight into this public health workforce development issue.

Research Question 1

How do urban public health employees experience the professional socialization process within their profession?

When looking back at the definitions of socialization, we see that these public health employees felt they received only partial knowledge, skills, and values necessary for successful entry into the field of public health. Weidman et al. (2001) define socialization as how "individuals gain the knowledge, skills, and values necessary for successful entry into a professional career requiring an advanced level of specialized knowledge and skills" (p. iii). Bucher and Stelling (1977) describe a ""programming effect," i.e., that the outcomes of socialization are, in large part, determined by the nature of the training program" (p. 257). I found this to be true with the 18 participants: those who were more committed to public health had stronger convictions that their socialization processes were good.

When describing various stages of socialization, some theories espouse that a new employee will achieve role clarity within the first year. This seems contradictory to what these 18 participants described. Very few were given role clarity. The few who found it discovered it on their own via trial and error. Many are still discovering it. Because of this critical stage being missed, few have gotten to the stages of commitment and high satisfaction in their career. "If human resource management strategies are implemented in a halfhearted, piecemeal fashion, they lead to predictable failure. Success requires a comprehensive strategy and long-term commitment that many organizations espouse but fewer deliver" (Bolman & Deal, 2008, p. 159).

Continuum Correlations

When reviewing the six continuums of Van Maanen and Schein (1979), a pattern for public health socialization emerges. Public health socialization is widely *individual,* based upon various unique circumstances, roles, and experiences. *Collective,* or group,

aspects included the possible attendance at a one-day state health department orientation or attending conferences. The socialization in public health is vastly *informal* and unstructured. What *formal* elements exist include possible regular meetings with a supervisor, but never more than 6 months into the career, as well as a bulleted list of videos to watch or an orientation checklist that is not typically followed. The only position that had an even remote s*equential* process with identifiable steps was that of the registered sanitarian. All other roles experienced *random* and *ambiguous* socialization processes. There existed no *fixed* timeframes for any of the participants beyond a few having a year's probationary status.

The public health socialization experiences of these 18 participants can be classified as *variable* or *flexible*. While some participants had role models among either their supervisor or co-workers, which thus could be defined as a *serial* socialization process, these role models happened more organically and in a piecemeal fashion. The public health socialization among these participants falls almost exclusively into the *disjunctive* domain; no role models were formally offered.

With regard to *investiture* versus *divestiture* socialization processes (i.e., investiture welcoming diversity and personal experience and divestiture seeking conformity), it appears that the public health supervisors of these participants sought neither, which lowered clarity and increased ambiguity. Participant comments described the supervisors as not seeking conformity, but not fully embracing personal experiences either and further pointing to supervisors being unskilled and untrained in mentorship. A few participants were forced into conformity within their positions by being stifled from cross-training and receiving incorrect definition of their roles. However, it did not appear

that conformity was an overt goal of the supervisors, who inadvertently pushed their employees to abandon creativity. Each of the above-described continuums shows that public health is currently characterized as having *individualized socialization*. As described by Ashforth and Saks (1996), individualized socialization accurately describes the socialization process in public health whereby it encourages “newcomers to question the status quo and develop their own approach to their roles” (p. 150) and does “occur more by default than by design” (Ashforth & Saks, 1996, p. 151) which unfortunately increases role ambiguity, conflict, and stress.

Correcting the Piecemeal Efforts

Whether the pace was fast or slow during those initial months, and with the length of socialization being relatively short for all of the participants, most were largely overwhelmed at the start of their careers with the default practice of the individualized socialization model. Research has shown that orientations are too short; instead, they should span the first two to five years of one’s career as opposed to the first few weeks or months (Anthony et al., 2011; Buchanan, 1974). Other research found that support for newcomers declines after the first 90 days of employment and identifies the need for socialization to continue over time (Kammeyer-Mueller et al., 2013; Wanous, 1992). This was found to be true with these 18 participants.

Even among those who are highly resourceful and have a high locus of control, impostership abounds. The leadership within public health could benefit from the utilization of more institutionalized socialization tactics for creating organizational commitment and job satisfaction while still capitalizing on the parts of individualized socialization that are working, to enhance innovation and performance (Ashforth &

Saks, 1996). Of course, not every newcomer would thrive in an individualized socialization environment, which may explain some of the participants' frustration.

Turban and Dougherty's (1994) research suggests that the characteristics of high locus of control and trust, good self-monitoring capabilities, emotional stability, and self-esteem have an indirect influence on career attainment, success, and job performance. This was found to be true in this research: those who were more resourceful fared better than those waiting to be told what to do. Many of these participants had to rely solely on their own proactivity and resourcefulness at the individual level because they received little social support to achieve the relational level and because socialization was not institutionalized at the organizational level (Smith & Hatmaker, 2014). If the scale of proactive behavior on the part of a new employee could be tipped more toward the side of organization-provided socialization, these new employees might not have felt so thrown in and left to figure it out.

Research Question 2

How do the organizational contexts elicit or diminish professional socialization processes in the field of public health?

Specialist or Generalist

In this research, the number of participants was exactly split (not by design), with nine specialists coming from the larger health department and nine generalists employed at the smaller health departments. A review of the specialist-versus-generalist concept was the main component chosen out of the multitude of organizational contexts that could have been reviewed.

It was found that there was no discernable difference in how the two types of public health workers were socialized. This distinction between public health workers was insignificant and virtually irrelevant. Their socialization experiences and needs were very similar whether they worked at a large agency or a small agency. I had theorized that the experiences would be vastly different and that the needs among the two groups would be different. The benefit of my theory being proven wrong is that this creates a much simpler, more efficient opportunity for all public health organizations to socialize their new employees in largely the same core manner. The only difference found to affect their specialist or generalist status was their personalities, which could possibly lead back to the issue of one's locus of control. Anna found it difficult to juggle the daily change and ambiguity of being a generalist:

> I think it's because it would just be so much, and there's not really time to really dive into all the stuff . . . because I don't think that any changes, like the mentoring or the orientation, would have changed that. It gets to be kind of tough, and that's one of the nice things about working in a special area is that your mind is constantly in that one spot, whereas trying to switch on a dime [as a generalist] . . . one minute someone is calling you about lead and the next about your mumps case. It's kind of hard to juggle.

Brittney experienced just the opposite. She wanted to experience the bigger picture of public health, which she did not get when working at a larger health department:

> [I did not need to necessarily be] trained in everything, but maybe even taking a day to go around to the other [divisions], because I really didn't know . . . there's

so many different things they do. I would have no idea until I came to the [smaller health department] what public health all encompasses.

Some of the participants brought up the dichotomy of public health nurses (PHNs) versus public health educators and how the future may show a move away from one-on-one nursing and other specializations toward a broader community perspective, with more foundational skills at the generalist level focusing on issues such as the social determinants of health and health equity. While this research did not delve further into this perception among some participants, it found that one does not need to be a specialist or an "expert" in some aspect of public health in order to feel like an insider or to identify with the profession. Today's public health specialists may need to be tomorrow's generalists.

Support Systems

With regard to the socio-cultural aspect of peer groups, it was found that peers ranked as the highest source of support (Spenceley, O'Leary, Chizawsky, Ross, & Estabrooks, 2008). This rang true among the participants who had experienced a truly supportive peer group. Support systems, also known as "agents," for any new employees entering the field (Bauer et al., 1998) are a necessity and fit into the larger context of professional socialization efforts. Such organizational roles are determinants in the effectiveness of the relational level function vital to identity development (Smith & Hatmaker, 2014). Of the participants who claimed that they had a mentor, I would counter that only three had a mentor by definition and that the rest had good coaches. This confirms the findings of Wiesman, Babich, Umble, and Baker (2016) that mentoring is rarely offered in public health, nor does it occur effectively. Bucher and Stelling (1977)

reiterate the benefits that a strong peer group plays an enormous role in professional identity development, positing that “having a strong peer group can be very helpful to the individual trainee in traversing a difficult system” (p. 269). Similarly, Louis et al. (1983) found that peers seemed the most beneficial to socialization development. Those who had peer groups stated how vital they were to keeping them in their careers.

Levett-Jones and Lathlean (2008) emphasize that in order to learn, new employees need to feel a sense of belonging in a caring, supportive, and team environment. They need to build social capital over an extended period of time to form trust and increase morale. This goes beyond individual-level socialization to the next level of creating supportive team environments (Hawley et al., 2011). “Public health leaders aiming to improve levels of job satisfaction should focus on workforce development and training efforts as well as adequate supervisory support, especially for new hires and nonsupervisors” (Harper et al., 2015, S46).

Participants who were employed in management positions said they were not given management training. They were not even trained in how to manage employees or handle human resource situations let alone how to socialize or mentor new employees. A few sought out their own management trainings online, while others just managed the way they would like to be managed. And if each of the participants’ managers had been trained in how to socialize or mentor, they did not put those skills to use with these participants. Schein (1978) stresses how critical the first boss is to a new employee’s future success, expressing the need for managers to be trained in how to socialize newcomers well. Other research also agrees around the importance of training supervisors and co-workers as to how to offer mentoring and support to new recruits

(Kammeyer-Mueller et al., 2013; Ostroff & Kozlowski, 1992), for it is those with whom new employees interact on a daily basis that have the most influence on successful socialization (Levett-Jones & Lathlean, 2008).

Bigger Picture

It was clear that the big picture was not conveyed to the participants during their socialization and, for many, still not in their advanced beginning or competent phases of their careers. Some were seeking to understand and asking their supervisors for parts of the big picture. Unfortunately, it was found that the six content dimensions relevant to new employees during their socialization process—politics, history, people, performance proficiency, language, and goals/values—were only sporadically incorporated into these participants' socialization (Chao, O'Leary-Kelly, Wolf, Klein, & Gardner, 1994), and often not by design. The emerging priorities for public health workforce development—systems thinking, communicating persuasively, change management, information and analytics, problem-solving, and working with diverse populations—were also included irregularly in the newcomers' training (Kaufman et al., 2014). Wilkins (1986) calls for political mentorship to help newcomers achieve political maturity thus expanding their transformational leadership skills. Political maturity can aid public health workers with understanding the broader culture of their career, thus knowing when to navigate, play, or even change the rules within public health politics.

Altering training and curricula to include some of the perceptively latent components of public health (e.g., communication, finance, health policy, law, cultural competence, and ethics) can prepare public health professionals for a deeper understanding of their professional identity (Cook et al., 2003), since early perceptions

of a public health professional identity may not include these components. While many received more in-depth training around their role specific tasks, "the balance between core and specialty training should be reconsidered" (Kaufman et al., 2014, p. 557). These perceptively latent components of public health and the strategic plans where mission and vision are communicated were lacking in participants' socialization and still being sought well into their careers. Ashforth and Saks (1996) argue:

> Most conceptual and quantitative empirical work on socialization effectively ignore macro factors, such as the size, structure, mission, and culture of the studied organization (or relevant sub-unit) and the occupation, and meso factors—such as intergroup dynamics, leadership styles, technology and job design, and reward and communication systems. (p.175)

Most of the participants had experienced the feeling that their agencies existed in silos. They all expressed desire to break down the walls. They want to be cross-trained and understand the bigger picture of public health and others' roles. But often times the participants felt that the leadership did not perform in a way or assist with a plan to break down silos within the organization. It was obvious how this trickled down to these participants, who perceived the use of ineffective leadership for the field of public health.

Other Contextual Concepts

Looking at the other organizational contextual concepts that were reviewed with this research, most had little impact on socialization experiences and formation of professional identity: role, time in agency/career, autonomy, job feedback, size of the organization/local public health agency (measured by workforce numbers), psychological climate (attitudes, expectations, and perceptions toward the department

and work), and management status. I hypothesize that these organizational contextual concepts did not have an impact due to both the small sample size and the degree to which participants did not discuss these topics. As with any bell curve, a few of the participants were outliers in that a few with a lot of job feedback were still only lightly committed to their career in public health. On the other end of the spectrum, one participant who experienced no social support and poor leadership expressed a favorable commitment to public health. More research would need to be done on the effect of each of these organizational contexts within public health as they relate to socialization and professional identity formation to further enhance socialization outcomes and tactics.

If using definitions identified in Chapter 2, it appears that many of the participants missed receiving knowledge of their organizational context: the informal rules and guiding behavior leading to values, heroes, rites, and rituals that define the environment, thus increasing productivity and building a cohesive network (Deal & Kennedy, 1982). Newcomers need to understand these organizational contexts "both a set of distinguishing features . . . and a set of universal principles guiding best practice" (Needle, 2001, p. 40). Snow et al. (1992) suggest that socialization engage the whole organization through integration of an organization's context and culture, which in turn will offer employees broader learning opportunities.

While the issue of funding was not studied in this research, it was brought up several times and thus warrants mentioning in relation to organizational context. In one regard, cities, villages, and municipalities lack the funding to focus on socialization efforts. Further efforts to increase socialization, such as induction programs and other

workforce development training, are often underfunded and not an organizational priority (C. A. G. Crawford et al., 2009). In another regard, large sums of grant money afforded some role-specific socialization to some but not to all. Kaufman et al. (2014) deduce that, “decades of categorical funding created a highly specialized and knowledgeable workforce that lacks many of the foundational skills now most in demand” (p. 557). As with all research into public health professional and workforce development, funding is a constant issue, and should be reviewed further.

Research Question 3

What influence does the professional socialization process have on the formation of a public health professional identity?

Establishing a distinctive professional identity has traditionally required that a group demonstrate distinctive characteristics that in turn generate a label or name that is associated with that distinctiveness (Giddens, 1997, as cited in Hurley, 2009, p. 384). While there is a distinctiveness to public health, practice professionals, including the participants in this research, often have trouble describing it to the broader community. This is especially pertinent to the field of public health, where some employees may “not have a clear perception of the specialization of their field and thus experience a professional identity crisis” (Okura et al., 2013, p. 8). It will be important for this issue to gain some clarification not only for employees within the field but for the community they serve. “A clarification of professional identity is also a clarification of professional responsibility towards the population and is related to the quality of work” (Dahl & Clancy, 2015, p. 680).

Identity Outcome from Lacking Socialization

A strong professional identity is necessary to work in an interprofessional environment such as public health according to Arndt et al. (2009), who coined the term “interprofessional familiarization.” This term reinforces what this research found: the need for teaching public health newcomers about the broader picture of public health and for enforcing cross-training. Knowledge of the broader strategic plan and latent components (e.g., communication, finance, health policy, law, cultural competence, and ethics), as well as an understanding of the various divisions and their missions, as many of the participants desired, would aid interprofessional familiarization. Membership and use of professional associations are another key factor in socialization that leads to professional identity, thus showing a “commitment to professional development” (Hayden, 1995). Better advertisement of various credentials and memberships can be displayed to new public health employees, many of whom do not seek out such memberships on their own. Lack of big-picture training and knowledge may explain why professional identity is so ill defined in the current workforce.

Most of the participants had a difficult time understanding and defining their own professional identity. Using other questions that garnered their professional identity status and level, a few themes emerged. These themes showed that the lack of a professional socialization process, including lack of internal and external mentors, peer groups, and networking opportunities, hindered the formation of any solid public health professional identity. Having these forms of social support to encourage newer employees to critically reflect on their experiences “can strengthen the collective identity and legitimacy of the profession” (Dahl & Clancy, 2015, p. 685), thus catalyzing the

integration of self and professional identity (McCrae et al., 2014). When asking the participants if they had ever reflected on their socialization prior to my prodding with the questions during the interview, most had said they had not processed things to the depth that I asked about.

As found in this research, professional identity can become superficial, displayed in "surface behavior," and lacking "deep attitudinal commitment" (McCammon & Brody, 2012, p. 259). Among the participants interviewed, very little internalization has occurred in their professional identity development, and there is even less embodiment of character, as is necessary for full identity with public health. This was shown through how few strongly identified as an insider within the field. Part of the issue is certainly with the silos and perception of poor leadership at the participants' agencies, leading to a lack of assurance. The greater an employee's confidence level within an organization, the stronger the association was toward manifesting a professional identity (Okura et al., 2013; Wells et al., 2000). However, setbacks can occur at any phase of professional identity development within a career due to lack of proper guidance and socialization (Okura et al., 2013), lack of supervisor training, or an inability to receive aspects of social learning alongside onboarding efforts (Wood, 2015). This also speaks to the need to lengthen a newcomer's socialization well beyond one year as opposed to the one to six months that currently exists. This will enable employees to weather the setbacks and changes that are always occurring within public health.

While a wide array of research discusses how socialization begins during one's academic career, some researchers have leaned away from the formation of a professional identity during one's education, or early career. Instead, that research

shows that wisdom—instead of knowledge, power, and agency—help pivot one's career toward the development of a stronger professional identity (Ibarra, 1999; Kao & Lin, 2015; Wood, 2015). In addition, such identity can dynamically morph throughout one's career (Monrouxe, 2010). One study found that public health professional self-identity could not gain a firm hold in one's psyche until 6 to 10 years of actual work had been completed (Okura et al., 2013). While I was hoping to see a much stronger singular professional identity among the 18 participants, these findings give hope that it may still develop, given more time and wisdom in one's career.

A Field in Flux

A role dichotomy that was mentioned a few times, and worth noting given this understanding of public health professional identity, was whether public health nurses would remain in public health given the decrease in individual care, with health educators and specialists handling more of the community health and healthy equity issues. This dichotomy was summed up by Freidson (2001): "Much work is likely to be performed in jobs whose very existence may be fleeting, and whose tasks may change. Such jobs can develop no coherent identity, and those performing them are unlikely to be inclined or able to develop common occupational identity and consciousness" (p. 47). The dichotomy might also explain the lack of resilience and "change fatigue" (Scholes, 2008, p. 975) of public health workers who have faced so many changes to their profession.

Changes to the public health identity include, but are not limited to: technological advances; new purviews such as becoming first responders after 9-11; a more informed public, forcing differing community demands; a move away from one-on-one patient

care to a larger, community-based model; increased leadership and critical thinking demands; various funding streams, including emergency preparedness, that compounds their workload; and onboarding of a new workforce, Millennials. The latter have widely differing viewpoints and visions of the future of public health thus blurring the role boundaries. While this research did not delve into these subjects, each warrants further research given that they seem to be issues that may bubble to the surface in the near future, thus turning the creation of a public health professional identity into a moving target. The fatigue in employees trying to identify with public health while it is ever changing may only push employees further from the career in search of more stability.

Similar to other studies (Hurley, 2009; McCrae et al., 2014), the participants were unable to identify “a meaningfully distinct role” with their profession or articulate “a unique domain of practice (McCrae et al., 2014, pp. 771-772). In smaller health departments where a more flat hierarchy exists, public health employees may find that the less pronounced status leads to more job satisfaction, given that they are more able to work with the community in a team environment and given more communication from leadership. However, this may lead to the inability to discern a public health professional identity due to “loss in role demarcation” (McCrae et al., 2014, p. 772), which is at odds with development of a clean and clear identity. Because of “lack of specific substantiation and explanations of the significance of their experiences” (Okura et al., 2013, p. 11), new public health employees often identify with whatever former career or program they graduated from.

A factor that was found to significantly and positively correlate to governmental employees deciding to remain with their current employer was a commitment to public service (Yeager et al., 2016). Many people enter the public health field because they see themselves as change agents who can “communicate the excitement, possibilities, and details of a change to others within the organization” (Rockley, Kostur, & Manning, 2003, p. 432) and to the public. According to a Syracuse University professor, a change agent is “any individual or group that performs purposeful educative activity designed to influence change in a practical or specific situation. Sometimes the term is used synonymously with facilitator, instructor, leader, planner, or teacher” (Hiemstra, 2009).

People with this type of passionate direction are needed in public health, where more leaders are necessary, for day-to-day health behavior change and for more effective population-level work to “assure the conditions in which people can be healthy” (IOM, 1988, p. 1) and especially during public health emergencies. Based upon participants’ feedback about desiring to make a difference and work within their community, public health programs should ensure more community work, which not only correlates with these employees’ prior expectations but can lead to a stronger professional identity.

Multi-dimensional Identity

Research posits that a move away from one definition of professional identity within a field is warranted (Clouder, 2003), and that the sum of a person’s knowledge, skills, and abilities be acknowledged within a diversity of professional identities from a person-centered approach (Hercelinskyj et al., 2014). Allowing for individual and personality differences within a professional identity definition avoids a singular and

fixed definition, and includes a “cluster of capabilities” (Hurley, 2009, p. 388), thus moving the study of professional identity away from early simplistic and monolithic definitions. All aspects of a person intersect with their profession, and if accepted by those within their profession, can lead to less impostership and less display of false or forced images of audacity.

It is clear that a multi-dimensional identity is necessary because of the varied activities of public health and because employees come from an even wider variety of backgrounds. Community public health practice has extremely blurred boundaries without clear role demarcation. It is not surprising that these participants were unable to articulate a specific professional identity. On the contrary, it is clear that such ambiguity is causing confusion and stress. One homogenous identity is not possible, and maximum individuality is necessary, constructed by internal and external factors. Public health cannot continually defer addressing this need for identity, waiting for a time when change slows. Let this be a “call to arms” for the field of public health in making grand changes to how we onboard newcomers and foster their public health professional identity.

Commitment

“Professional identity and commitment to a profession are so intricately intertwined as to be virtually inseparable” (Bucher & Stelling, 1977, p. 215) but may be specific, involving allegiance to only one particular subgroup, one’s colleagues, or type of work within the field. All in all, this research sought to determine the extent to which employees tie their identity to a public health career, not merely a commitment to the agency itself or even a job title. Occupational choice and commitment are core

attributes of identity . . . suiting the perception we hold of ourselves (Kroger & Marcia, 2011). A question was asked of each participant: To whom to you ally yourself with most: your job role, the agency you work for, or the field of public health in general? Only five (28%) allied themselves with the profession over their job role or agency. And only 39% (seven) saw themselves definitely still working for public health in 5 years.

This warrants review by public health leadership to determine why a commitment to the profession is lacking and how the leadership can alter socialization to increase the amount of newcomers that ally themselves with the field in general. A profession cannot sustain itself when identity numbers are this low. Retention rates should be reviewed in future research to determine exactly why people are leaving and how to alter organizational culture and policies to retain newcomers. “Loss of talented practitioners trained at public expense will have adverse impact on the drive to improve quality of care” (McCrae et al., 2014, p. 773). We must work to attract and retain a qualified public health workforce through better socialization efforts, or the field of public health will be in peril.

Limitations

One threat to this study’s validity may be sample size, as the sample size of 18 may be considered small. Another limitation of the research could be that participants may not have been honest or forthcoming with their responses. For example, one participant, even with confidentiality guarantees, was very worried about being identified, so answers were short of depth. Another participant was disgruntled with their agency of employment and its leadership, which may have impacted their answers to the questions. But given the strong universal composite description and the clear

themes from the data that emerged, this research should not be dismissed as "complaints of new employees who don't know anything." Similar to another study, "a weakness of the study is a lack of long-term outcome. The short-term impact can be seen in the way that [participants] struggle to define their early professional identity" (Wood, 2015). In addition, the dichotomy of my being a public health peer and researcher may have influenced participant responses. While I bracketed out my own socialization experiences as a newcomer in the same field as the participants, my own experiences were used to develop the research questions and thus could have impacted the research findings.

Finally, this pool of participants was limited to and included only five males and two African Americans (although these numbers over-represented male public health workers by 13% and African American public health workers by 7%). In addition, the participants ranged from having worked at least one but not more than 7 years in the public health field, including both "advanced beginners" with at least one year of experience to "competent" employees with 3 to 7 years' experience (Benner, 1984, 2001; Dreyfus & Dreyfus, 1980). I found that several of those who had 4 or more years of experience made a comment to the effect of "that was so long ago" in remembering their academic career or their first weeks on the job. This may have altered their answers. Future research into public health socialization, especially that which reaches back into academic years, may want to consider only looking at "advanced beginners" for more reliable information. Lastly, this research was definitively split with all of the specialists stemming from the larger health department and all of the generalists from the smaller health departments. Surely there are generalists within larger health

departments and specialists within smaller health departments that this researcher did not come across, but which future researchers should seek out for study.

Implications for Education

Regarding the repeated feeling that participants' college careers did not prepare them for the field of public health (and often did not present it as an option), it is important for academic undergraduate and associate programs—including but not limited to nursing, environmental health, health education, and social work—to offer public health as an alternative and equally rewarding career path. This must include a semester or full rotation for nursing programs and comprehensive internship opportunities.

Current programs sometimes offer courses or programs with a population healthcare focus, which is not to be confused with public health. While knowing population health is vital to operationalizing public health, it is but one component of public health. This academic population health often has a more clinical focus, preparing students for how to identify certain populations, assess their needs, and how to intervene both clinically and educationally but not at the administrative level of public health. Taking classes to a long-term care facility to run a clinic or put on a program does not convey public health sufficiently and shows that educators and program planners also do not understand public health. Having state and local public health professionals who actually work in the field to present to classes and assist with class projects would be advisable if such presenters are dynamic and can energize. Given that public health employees come from so many different backgrounds and academic paths, the experiential learning theory posits that "on-the-job" learning is a main

ingredient to public health competency development (Hughes, 2003). But this should not mean that we avoid any corrections to the academic foundation for the field of public health, detailing the distinction between population health and public health.

Implications for Public Health Practice and Workforce Development

The research outcome of this study seeks to have catalytic validity that moves others to action. At the macro level, with regard to nationwide public health, much more research needs to occur. But that research cannot just remain in the academic realm. It must be broadcast and utilized by public health agencies at all levels and in all regions, for it does no good to the field if empirical research is not being translated into best practices that are readily usable in the field. Public health's national organizations can also do a better job of translating empirical research on socialization and onboarding into practice as well as creating cross-collaborations between academic competency sets and their own competency set development. But even beyond the myriad of competency sets, national organizations and committees working toward improving workforce development can ensure cross-collaborations between themselves and academia and practice partnerships that are often vague and muddled.

This research substantiates that elements of various competency sets are missing from new public health employee training. This is similar to what Amodeo (2003) found when questioning the "appropriateness of initial training" (p. 500) and supposing that the current workforce has minimal to no training in public health "core competencies of traditional public health practice, much less the skill set necessary to work with communities" (p. 502).

It is vital to the development of the public health profession that we perform more research into how new public health employees are socialized and whether that has an impact on their professional identity formation. Once a strong base of research is created, practitioners can implement methods, and researchers can manipulate variables, in order to identify adjustments to and new methods for comprehensive socialization that can aid in new public health employee retention, job satisfaction, role clarity, and decreased turnover while employees are developing a professional identity.

This study is significant for the field of public health because little is known about the topic, yet many funding and policy decisions are being made surrounding the presence and quality of the public health workforce. There is a great need to understand professional identity for the future of public health and for better application of tax dollars applied to public health. This is because there exists a “general lack of political support for public health [as it] is just not a priority for our legislature . . . competes with fire and police for funding” (Draper et al., 2008, p. 4). In addition, public health is “being asked to do more with fewer resources, assuming larger caseloads, and trying to manage demanding federal grant requirements” (Draper et al., 2008, p. 5). These funding issues “often preclude offering [orientations] with the frequency needed for them to be timely for all new hires” (Klein & Weaver, 2000, p. 62).

Implications at the micro level are that each agency has room for improvement and can make adjustments for better functioning. Current local and state government economic realities are forcing public health agencies to review their services and programs, streamline staff, and create efficiencies throughout operations. Accountability requests come from boards of health, city councils, and, especially, from the community

and citizens that a public health agency serves. Health officials must show proof of their productivity and scalability to streamlining programs and staff. Research surrounding the socialization efforts of public health can have far-reaching effects into all levels and services on job satisfaction, role clarity, and retention in the field.

Poorly socialized public health newcomers may likely become someone else's first boss in just a matter of years, thus perpetuating the cycle and defying a change in organizational culture. Hopefully this research fosters a conscientization in public health leaders, spurring them into action to develop better socialization programs and to consider stronger development of a public health professional identity. Many have acknowledged the need for more investment in workforce development and training, but the infusion of substantial funds for new hiring is unlikely in the near term. This creates a problem for investing in the development, training, and retention of existing workers, which is so critical (Draper et al., 2008). The recommended actions below offer low-cost and easy ways to improve socialization for new employees. The results of this research explore how each agency faces socialization problems similarly, regardless of size of agency or type of role. Instead of each local health department having to recreate and adapt socialization programs, collaboration and coordination on broad and general socialization efforts can solve the problem collectively.

Implications for Future Research

Further research could quantitatively look at how public health professional identity relates to newcomer socialization, including research on insider status (or lack thereof) and how impostership affects identity. It would be useful to determine if a clear professional identity truly leads to improved retention, job satisfaction, role clarity, and

decreased turnover in the field of public health, as has been shown in other disciplines. Or more simplistically, why *do* people stay within the field of public health? Quantitative research should further assess how much socialization processes serve a vital role in assuring that public health employees remain in the field with higher levels of job satisfaction and performance because they have been thoroughly trained and socialized upon career entry.

Further, it would be beneficial to review all of the above by looking at how professional identity develops through the lens of gender, race/ethnicity, and across the various roles within public health, from health officers and supervisors to nurses, sanitarians, and even clerical staff within the field of public health as mentioned by the Public Health Service of the U.S. Department of Health and Human Services (1997). Beyond roles, is there a difference between large and small health departments? Both qualitative and quantitative studies are necessary to build the research base for this topic, both short-term or limited as well as longitudinal studies.

Other angles could include: research on person-organization fit and how that affects longevity with a public health agency (Lewis, 2014) and research conducted with special attention to various organizational contexts, in order to bring about more specific advances and actionable tactics that can be directly implemented in a public health agency. This research generated a few interesting questions: At the organizational level, is there a critical mass of appropriate socialization in an organization, above which a virtuous cycle is self-sustaining but below which a vicious cycle ensues (Swain, 2017)? Do current public health leaders value a clear professional identity as a way of recruiting and retaining fresh leadership and talent? How are students in various related

programs encouraged to want to work in the public health field? And perhaps most valuable and related to this research, in what ways is public health socialization and professional identity development occurring successfully?

Recommendations for Action

Supervisors

A fundamental first step may be to ensure that any supervisors are trained in how to be good mentors and how to socialize newcomers, in addition to simply learning how to manage. Having supportive supervisors trained in proper, studied methods for administering socialization (Kammeyer-Mueller et al., 2013; Ostroff & Kozlowski, 1992) can decrease the self-doubt and feelings of impostership among new employees and tackle the siloed culture among some health departments. It is difficult for new employees to find mentors and establish suitable relationships, leaving much of the burden in this recommendation to fall on the public health agencies and their leadership. Because mentoring relationships take time to develop, organizations need to commit to long-term support of mentoring relationships. In public health, and government in general, most issues do not have clear resolutions. Assisting new employees with how to navigate contradictory experiences, make decisions, and wade through an ever-changing environment will be vital for future success.

Professional memberships

State public health associations can modify their models, which may be currently catering to those who are motivated and active within their membership, and seek out new employees, thus recognizing their part in establishing a public health professional identity. Capturing new employees with an active and ongoing marketing campaign that

is clear in detailing its membership benefits would aid in many more joining and thus being active, involved members. Stepping into a role of cheerleader to encourage a love of the profession, generating excitement, and providing connections can be the role of a statewide professional organization.

Statewide Orientation

Given that the statewide orientation only occurred twice a year, its timing became a problem for newcomers to attend, or its information became irrelevant or outdated. If the presentations of this public health orientation could be made into videos, new employees could be required to watch them between their third and fifth months, when participants stated it would have been most beneficial. Videos could allow for an open dialogue online with questions and answers. The other part of the orientation that could have been improved—and appeared to be vital for new employees—was the networking aspects of the new employee orientation. These live networking opportunities could still occur twice a year and include much more social interaction.

It is imperative for all public health agencies to approve employees' ability to attend and encourage new employees to become active in the online community and attend the various networking events. These events could potentially be collaborative efforts between the state health department and the state public health association. Other collaborative efforts can include best practice sharing of orientation videos across state and local agencies for one approved list all would benefit from, thus lowering the need for new employees to be forced into being resourceful in isolation.

Increase Community Involvement and Other Tactics

Given that so many of the participants had expectations upon entering the career of working with the community, and that this aspect of their work provides the greatest satisfaction, it would be beneficial to incorporate more of the community into program planning and other internal efforts. Allowing public health employees to perform more outreach into the community would also bridge this gap and thus place the "public" back into "public health."

More detailed tactics that have proven successful in other fields including rewarding high-functioning employees, staff retreats, better top-down communication, more joint decision-making opportunities, and flexible schedules without overtaxing workloads (Campbell et al., 2004; Pourshaban et al., 2015). A recent case study of local public health agencies showed promising practices such as: cross-orientations, using data to support workforce planning efforts, and incorporating behavioral competencies and emotional intelligence into workforce trainings (Darnell et al., 2013).

In line with other research, and as suggested during participant interviews, I recommend the following components be coordinated by supervisors and leadership at each public health agency in addition to role-specific knowledge and skills, thus bringing a better balance to core *and* specialty training:

- Enact a multi-faceted, comprehensive, planned, and purposeful socialization protocol and onboarding program that not only embodies, but is implemented with, full integration and participation of the "collective professional community" (Anthony et al., 2011). This program should be committed to lasting at least one full year for each new employee thus adding more institutionalized socialization

to the current individualized onboarding system and building new employees along a continuum of professional learning, not simply for management of learning activities or for achievement of certain competency tasks and levels – meaning the "object of long-term professional learning rather than short-term survival and fit" (Anthony et al., 2011);

- Create a culture where asking many questions is welcomed and may even lead to new input or changes in protocols, seeking diversity and not conformity in creating a supportive team atmosphere;
- Allow participation or provide infrastructure for residency programs, Communities of Practice (CoP), and other onboarding efforts from the start date for each new employee;
- Include newcomers in collaborations with local colleges and universities, finding ways to create deeper academic linkages that can assist departments and programs; present to academic classes including non-public health tracks (e.g., nursing, nutrition, biology, epidemiology, and social work);
- During Each New Employee's 1st and 2nd Month:
    - Share structure, mission, and culture; intergroup dynamics; leadership styles; technology; job design; reward and communication systems; and the informal rules and guiding behavior leading to values, heroes, rites, and rituals that define the three various environments (i.e., field of public health, local agency/organization, and sub-unit/division) (Ashforth & Saks, 1996; Deal & Kennedy, 1982);

- Negotiate tasks, projects, pace, and outcome expectations including training needs and wants between supervisor and new employee into a written contract;
- Overtly acknowledge the overwhelmed feeling in newcomers, be present, and adjust the pace as necessary. Describe that it will take years to fully understand things and feel comfortable;
- Initiate formal and informal mentorship opportunities (within and outside of the employee's agency), including close role models (Okura et al., 2013);
- Support peer connections and encourage social interactions and networking during work hours and beyond;
- Implement a formalized training and professional development plan that includes use of various competency sets, assessments, accountability components, strategic plans, quality improvement concepts, community health assessments (CHA), community health improvement plans (CHIPs), acronyms, and terms (e.g. municipality, jurisdiction, home rule, centralized vs. decentralized vs. hybrid state/local organizational models, social determinants of health, and health equity). Continually revisit this throughout the first year and beyond;
- Assist with filling in the gaps of resource finding and who to call for advice and opinions on job-related tasks working within a statewide framework that can provide more standardization than national policies;
- Enact observation of others and other divisions/units/programs for interprofessional familiarization and cross-training on at least two

divergent programs to avoid silos (Arndt et al., 2009; Meagher-Stewart et al., 2004);

    - Increase knowledge of various diseases, how to do case management, and epidemiology as the basis of public health;
    - Provide ongoing feedback that fosters confidence (at minimum: weekly for the first month, monthly for the next 6 months, and then annually).
    - Encourage reflective writing that can be shared with supervisors in part as a record of work and for continued touching base of emotions and uncertain components of the position and agency in an effort to achieve expansive professional inquiry, development, and theorizing (Anthony et al., 2011).

- Month 3 for Each New Employee:
    - Inclusion to and/or knowledge of governmental political foundation and perceptively latent components of public health (e.g., communication; financial structures/funding streams, both grants and tax levy; and how the accounting breakdown impacts each employee’s programs, health policy, law/statutes/ordinances, cultural competence, and ethics) (Cook et al., 2003; Ye, Leep, Robin, & Newman, 2015); and
    - Take all employees through a grant cycle process, over the course of one fiscal year, regardless of their involvement in grants.
- Beginning in Month 5 or 6 for Each New Employee:
    - Educate for an understanding and inclusion in planning concepts such as mission, vision, goals, SMART objectives, modes for analysis (e.g.,

SWOT/SLOT, PEST/PESTLE/STEEPLE), focus groups, and other strategic and program planning processes;

- Include a theoretical base training on use of public health theories, behavior change theories, and adult learning theories and assist in applying to each new employees job role (Alvenfors, 2010, as cited in Holko, 2011);
- Incorporate management and leadership training and experiences (Okura et al., 2013) even if not employed in a management role; explain why things are done the way they are and how higher decisions are made;
- Train on emotional intelligence;
- Link new employees to community members in order to provide more opportunities for employee satisfaction, thus meeting their initial expectations of public health;
- Encourage professional membership association joining and participation; encourage certification attainment (Hayden, 1995);
- Assist with reading, understanding, and incorporation of national and international empirical research for wider understanding/evidence informed decision making (EIDM);
- Allow regular opportunities for new employees to critically reflect on transformative experiences thus far to assist with identity building and strengthening reflective practice (Benner, Sutphen, Leonard, & Day, 2010; Dahl & Clancy, 2015)

- Educate on emerging priorities for public health workforce development, regardless of rank or leadership status, including systems thinking, communicating persuasively, conflict resolution, change management, information and analytics, problem-solving, and working with diverse populations (Kaufman et al., 2014); and
- Deeply discuss public health accreditation and other state reviews while sharing the measurements for achievement even if not currently being sought.

- Review all of the above at each annual meeting to recap and update on any changes enforcing a continuous learning cycle.

Researcher's Reflections

Having worked in and around the field of public health for the past 15 years, I am integrally related to this research from my own personal experiences and now via this research agenda. Public health is now a personal value that is integrated into my life and passions. My vision for a stronger public health employee base have become a lighthouse beacon. I desire to put my energy toward creating stronger support for boots-on-the-ground public health workers, who should take public health workforce development to new levels and premise their changes on a research base started by this study. More effective organizations create healthier communities. And the potential of every employee should be maximized to improve the overall public health workforce.

Interviewing the 18 participants was thrilling, but it grew my desire to mentor and be a resource advocate for new (and possibly struggling) public health employees. It was almost painful to bracket my own preconceptions, experiences, and opinions out of

the interviews and subsequent thematic review. Yet it was also pleasurable to tell the story of these participants from their lived experience alone even as I connected deeply. Bracketing was the most difficult barrier to overcome.

Early in the transcription process (because I transcribed after each interview), I noted that I was providing too many verbal clarifications (e.g., “Another way of considering this questions is to think of it as…”) and nonverbal affirmations (e.g., “MmmmHmmm”). What was not conscious during the initial two interviews, became abruptly apparent during transcribing, in a way that annoyed me. Transcribing after each interview became quite the learning experience in how to be a better interviewer, leaving time for the “uncomfortable” silence and not always having to give non-verbal agreement that I hear what they are saying. In all later interviews, my conversational nature was purposefully minimized.

Conclusion

This research warrants review by public health leadership to determine why a commitment to the profession is lacking and how the leadership can alter socialization to increase the amount of newcomers that ally themselves with the field in general. A profession cannot sustain itself when identity numbers are this low.

Public health leaders need to acknowledge the immense, overwhelming feelings of new employees by adjusting the pace of the first few months and providing much more social interaction by means of mentors, peer groups, networking, community involvement, and regular standing feedback meetings by supervisors. In addition, development of a consistent socialization program that includes the broader aspects of public health, such as strategic planning, accreditation, competencies, political aspects,

financial, interprofessional familiarization, and outside agency network and resource gathering would aid in the elimination of silos and bring leadership closer to newcomers, thus decreasing isolation and impostership feelings. Overall, assisting new employees to gain a big-picture understanding and providing opportunities for inclusion through social environments and professional memberships would assist in helping new public health employees identify with the culture and profession of public health. Then when these new employees become someone else's first boss in just a matter of years, the cycle will be broken, and we may begin to see a change in organizational culture.

Clarifying a professional identity for each new public health employee will not be a quick or easy task. But it is something that we must work to achieve, because we need to successfully continue to assure the health of our communities now and far into the future. Public health is a dynamic, exciting, and growing field that brings people together from a wide variety of backgrounds and education. With a mission to serve and improve the health of others, it is a field that will continue to evolve.

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APPENDIX A:

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FILE HOME INSERT PAGE LAYOUT FORMULAS DATA REVIEW VIEW ACROBAT J. Freiheit

H3 — This paper describes research commissioned by Skills for Care South West to identify and track the learning and development needs of newly qualified social workers through

	Authors	Year	Article Title	Publication	Full APA Citation	Primary Focus	Type	Synopsis/Abstract/Summary of Content	e foun	Annotation	Theory	Method
8	Nassar-Abu Alhija, F., & Fresko, B.	2010	Socialization of new teachers: Does induction matter?	Teaching and Teacher Education	Nassar-Abu Alhija, F., & Fresko, B. (2010). Socialization of new teachers: Does induction matter? Teaching and Teacher Education, 26, 1592-1587.	Mentoring	Quantitative	The present paper focuses on new teachers' satisfaction with their first year of teaching from the perspective of socialization. The relationship between satisfaction with socialization and teacher background, school environment, placement, and induction variables was examined. Data were collected from 243 Israeli beginning teachers by means of questionnaire. Results indicated that satisfaction during the induction year was moderately high. Hierarchical regression analysis showed five significant predictor variables: ecological support from mentor, help from the principal, assistance from other colleagues, workload, and having already completed teaching training. Support from mentors and school colleagues had the greatest impact on new teachers' assimilation.	Dropbox>Dissertation> Teacher Induction	One can tell that this article has the same authors as the above article as they cite many of the same claims and sources. Just a spin off from that other study...this time on socialization...but can be related to TPI as there are strong references to that here. Distinction needs to be made of mentors vs colleagues with regard to new employee socialization. Induction programs aid this.	socialization	questionnaire
9	Scherff, L.	2008	Disavowed: The stories of two novice teachers.	Teaching and Teacher Education	Scherff, L. (2008). Disavowed: The stories of two novice teachers. Teaching and Teacher Education, 24, 1317-1332.	Mentoring	Qualitative	This case study used narrative inquiry to explore two novice English teachers' experiences in the classroom and factors that caused them to leave the profession. Participants were one male and one female located in two southeastern (US) states. Data include transcripts of e-mails, spanning a 17-month period, between the participants and researcher and individual audio-taped interviews conducted by the researcher in May 2005. The teachers' narratives of disavowal reinforce the need for strengthening induction and mentoring programs, as well as the fostering of caring, healthy work environments.	Dropbox>Dissertation> Teacher Induction	Heavily related to socialization of new teachers and the need for all the various people involved in a new teachers career.	narrative inquiry	case study (data from transcripts of emails)
			How do state-level induction					Since the early 1980s, states have been increasingly active in setting policies that structure the initiation or "induction" of new teachers into teaching. This article uses the Schools and Staffing Survey merged with state-level data collected for Education Week's "Quality Counts" reports to examine the impact of state policy on beginning teacher turnover. States that mandate participation in induction programs tend to have more beginning teachers mentored, although state-level funding for				

Mentoring | Induction | Coding | Retention | Socialization | Prof ID and org context | PH stat ...

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APPENDIX B:

Empirical Sources			
Title & Author(s)	**Year**	**Method**	**Results**
Job satisfaction and expected turnover among federal, state, and local public health practitioners Leider, J. P., Harper, E., Shon, J. W., Sellers, K., & Castrucci, B. C.	2016	Data from the 2014 Federal Employee Viewpoint Survey and 2014 Public Health Workforce Interests and Needs Survey using logistic regression to examine job satisfaction and intent to leave.	Job satisfaction increases with: pay, support, involvement. Approximately 40% of federal, state, and local staff said they were either considering leaving their organization in the next year or were planning to retire by 2020. This was especially true with younger, more diverse, and more educated staff. Succession planning is necessary.
Succession planning and management practice in Washington State local public health agencies Wiesman, J. M., Babich, S. M., Umble, K., & Baker, E. L.	2016	Web-based, cross-sectional survey of succession planning practices and followed the career paths of public health officials for 40 months.	85% of agencies selected high-performing high potential employees for development, 76% sent them to formal technical and management/leadership training, 70% used cross-functional team projects, and 67% used stretch assignments to develop their employees.
Why do people work in public health? Exploring recruitment and retention among public health workers	2016	Cross-sectional study employed a secondary data set from a 2010 national survey of US public health workers; Data	Job security and competitive benefits were significantly and positively associated with governmental employees' decisions to take positions with their current employers compared with public health workers employed by other types of organizations. Two personal factors, personal commitment to public service and wanted a job in the public health field, were significantly and positively related to governmental employees deciding to remain with their current employers.

Yeager, V. A., Wisniewski, J. M., Amos, K., & Bialek, R.		examined demographics of public health workers and factors that influenced decisions to take jobs in and remain in public health.	
Meanings of knowledge and identity in public health nursing in a time of transition: Interpretations of public health nurses' narratives Dahl, B. M. & Clancy, A.	2015	Interview of 23 nurses.	"Critical reflection on [PHNs] experiences in communities of practice can strengthen the collective identity and legitimacy of the profession" (p. 685). 'Specialized generalist' public health nursing identity explored.
Succession planning in local health departments: Results from a national survey Darnell, J. S. & Campbell, R. T.	2015	National cross-sectional Web-based survey of workforce recruitment and retention activities in a sample of LHDs responding to the National Association of County & City Health Officials' 2010 Profile Study and then linked these data sets to fit a multivariable logistic	39.5% reported having a succession plan. Performance evaluation activities are more common in LHDs with a succession plan than in LHDs without a plan. In adjusted analyses, the largest LHDs were 7 times more likely to have a succession plan than the smallest. Compared with state-governed LHDs, locally governed LHDs were 3.5 times more likely, and shared governance LHDs were 6 times more likely, to have a succession plan. Every additional year of experience by the top executive was associated with a 5% increase in the odds of having a succession plan. Local health departments that report high levels of concern about retaining staff (vs. low concern) had 2.5 times higher adjusted odds of having a succession plan.

		regression model to explain why some LHDs have succession plans and others do not.	
Job satisfaction: A critical, understudied facet of workforce development in public health Harper, E., Castrucci, B. C., Bharthapudi, K., & Sellers, K.	2015	Cross-sectional study using data collected from the 2014 Public Health Workforce Interests and Needs Survey (PH WINS). Descriptive and inferential statistics were analyzed using the balanced repeated replication method to account for the complex sampling design. A multivariate linear regression was used to examine job satisfaction and factors related to supervisory and organizational support adjusting for relevant covariates.	Characteristics related to supervisory and organizational support were highly associated with increased job satisfaction. Supervisory status, race, organization size, and agency tenure were also associated with job satisfaction.

Constructing a structural model of teachers' professional identity Kao, Y. S. & Lin, S. P.	2015	Questionnaire of 487 Taiwanese teachers	Perception of external pressures and expectations had a significant direct effect on prof id. Transformational leadership suggested to enhance these; Idea that more power and agency will lend to a stronger id; Constant interpretation and re-interpretation of professional identity.
Loving and leaving public health: Predictors of intentions to quit among state health agency workers Liss-Levinson, R., Bharthapudi, K., Leider, J. P., & Sellers, K.	2015	Cross-sectional design. Balanced repeated replication was used as a resampling method for variance estimation. A logistic regression model was used to examine the correlates of intentions to leave one's organization within the next year. The independent variables included several measures of satisfaction, perceptions about the workplace environment, initial reasons for joining public health, gender, age, education,	Greater employee engagement, organizational support, job satisfaction, organization satisfaction, and pay satisfaction were all significant predictors of lower intentions to leave one's organization within the next year. Succession planning should be a priority.

		salary, supervisory status, program area.	
Building and sustaining strong public health agencies: Determinants of workforce turnover Pourshaban, D., Basurto-Davila, R., & Shih, M.	2015	Cross-sectional study using data collected from the 2014 Public Health Workforce Interests and Needs Survey (PH WINS).	Pay and job satisfaction are the most important predictors of intentions to leave other than retirement. Workplace characteristics such that can improve job satisfaction include “improving relationships between employees and supervisors, avoiding excessive workloads, improving communication between senior leadership and the general workforce, ensuring workers can apply their skills in their regular work, and improving workers’ perceptions regarding the importance of their own work and how it contributes to the agency’s goals” (p. S88).
The public health workforce interests and needs survey: The first national survey of state health agency employees Sellers, K., Leider, J. P., Harper, E., Castrucci, B. C., Bharthapudi, K., Liss-Levinson, R., Jarris, P. E., & Hunter, E. L.	2015	Nationally representative survey of central office employees at state health agencies (SHAs).	Although the majority of staff said they were somewhat or very satisfied with their job, as well as their organization, more than 42% were considering leaving their organization in the next year or retiring before 2020; 4% of those were considering leaving for another job elsewhere in governmental public health.
Learning, assessment, and professional identity development in public health training Wood, A.	2015	15 Semi-structured interviews	Need the right people in the workplace, trained in both social purpose and knowledge of socialization. Lack of congruence in workplace; struggle to define early professional identity. Knowledge leads to skill and wisdom.
Perceptions from the front line:	2014	11 interviews in explorative	Need to move away from one definition and sum a person’s knowledge, skills, and abilities (like Hurley) into a diversity of professional identities from a person-centered approach.

Professional identity in mental health nursing Hercelinskyj, G., Cruickshank, M., Brown, P., & Phillips, B.		descriptive design	
“You can’t learn it in school”: Field experiences and their contributions to education and professional identity Hoffmann, K. & Berg, S.	2014	16 interviews of library students analyzed by grounded theory	Authentic work experiences, informal training, being treated as equals; linking education with practice; role modeling; field experiences that provide a space whereby mistakes are okay.
Thinking beyond the silos: Emerging priorities in workforce development for state and local government public health agencies Kaufman, N. J., Castrucci, B. C., Pearsol, J., Leider, J. P., Sellers, K., Kaufman, I. R., Fehrenbach, L. M., Liss-Levinson, Lewis, M. R., Jarris, P. E., & Sprague, J. B.	2014	Key informant interviews were conducted with 31 representatives from public health member organizations and federal agencies.	Systems thinking, communicating persuasively, change management, information and analytics, problem-solving, and working with diverse populations were the major crosscutting areas prioritized for training
Merely a stepping stone? Professional identity and career prospects following	2014	10 nurse interviews.	Allowing self-reflection; jack of all trades; inability of participants to present a meaningfully distinct role (p. 771); flat hierarchy’s leads to role satisfaction but loss of role demarcation which detracts from professional identity; status incongruence.

postgraduate mental health nurse training McCrae, N., Askey-Jones, S., & Laker, C.			
Professional identity negotiation during organizational socialization in the context of solution focused therapy training Noll, D.	2014	Existing dataset of 30 semi-structured interviews and ten logbook files from ten health care respondents which were combined with observations	Information-seeking and negotiation strategies: approaches labeled as compliance (using taught methods as is), cooperative (finding solutions together), directive (take lead with still some input from others), doing what works (deviation from taught methods in a creative manner), and commanding (refusing taught methods and taking charge). These strategies offer a new way of understanding how professional identity is negotiated.
Knowing, doing, and becoming: Professional identity construction among public affairs doctoral students Smith, A. E. & Hatmaker, D. M.	2014	Interviews of 27 doctoral students who participated in a professional development workshop for public affairs.	Professional identity tactics categorized into three main groups, each suggested for complementary implementation: institutionalized socialization (at the organizational level), faculty mentoring (relational level), and individual proactivity: relational being the “most central to the students’ professional identity development (p. 557). Newcomers engage their own agency, a large portion of socialization processes in addition to formal programs within an organization.
Support, undermining, and newcomer socialization: Fitting in during the first 90 days Kammeyer-Mueller, J., Wanberg, C., Rubenstein, A., & Song, Z.	2013	14-wave longitudinal study with 264 newcomers.	Support declines within first 90 days from coworkers and supervisors; Supervisor undermining uniquely associated with higher turnover. "proactivity is more likely when the appropriate initial social environment is present together with a pattern of continued support" (p. 1118) as this study finds that support is needed over time.; supervisors and co-workers should be trained on how to give support; social dynamic.

Factors that affect the process of professional identity formation in public health nurses Okura, M., Uza, M., Izumi, H., Ohno, M., Arai, H., & Saeki, K.	2013	Qualitative analysis based on semi-structured interviews and focus group interviews of 65 PHNs	PHN professional self-identity did not develop until years 6-10 of work. Without a clear identity, there were setbacks at various career stages. Level of confidence also played a role in whether a PHN formed a professional identity.
Developing trust with peers and leaders: impacts on organizational identification and performance during entry Schaubroeck, J. M., Peng, A. C., & Hannah, S. T.	2013	512 US Army soldiers at beginning, middle, and end of a 14-week training and socialization program.	Social exchange relationship influences newcomers: peers and leaders; positive reciprocation and shared obligations= high trust which means stronger commitment and better use of resources as a newcomer; socialization is ongoing given that new trust relationships are formed throughout a career; peer relationships enhances organizational identity.
The power of the 'object' to influence teacher induction outcomes Anthony, G., Haigh, M., & Kane, R.	2011	Longitudinal mixed methods with New Zealand secondary teachers (questionnaire and interviews).	Exemplar objects of induction were 'orienting to learning about the context', 'fitting into the school', 'completing registration/accreditation requirements', and 'becoming a professional inquirer' (p. 865). "In order to better achieve the shared object of long-term professional learning rather than short-term survival and fit, there [needs to be] ample scope for increased collaboration between [newcomers] and their experienced colleagues" (p. 868). Recommends socialization for teachers lasts at least 2 years. Detailed components of multifaceted induction programs described. Programs should be integrated into an organization's culture, as a whole organization learning opportunity, adapting "policy guidelines to match individual [employees] level of experience"
Organizational commitment through organizational socialization tactics Filstad, C.	2011	179 administrative staff completing a measurement tool based on Van Maanen and Schein's theory on organizational socialization tactics and	Social dimension has a strong positive relationship with org commitment: providing role models, support and acknowledgement from colleagues, and participation in work activities. Formal training and career dev does not necessarily lead to organizational commitment. Respondents may confuse this assessment's factors thus rendering the measurement invalid. It may imply that formal learning is superior to informal.

		Kuvaas' measurement tools of organizational commitment.	
Generating social capital through public health leadership training: A six-year assessment Hawley, S. R., St. Romain, T., Rempel, S. L., Orr., S. A., & Molgaard, C. A.	2011	Pre and post assessment of 130 public health leaders.	Social capital, the social networks developed from reciprocity and trust, increase worker morale and skill level beyond individual-level skill building. A year long leadership training program increased social capital.
A nursing career in mental health care: Choices and motives of nursing students Hoekstra, H., Van Meijel, B., & van der Hooft-Leemans, T.	2010	100 completed preliminary questionnaire and 13 interviewed	Stereotypes and prevailing opinions affect recruitment into certain health programs; training about choices of major in academia can assist.
Socialization of new teachers: Does induction matter? Nasser-Abu Alhija, F. & Fresko, B.	2010	Questionnaire of 243 Israeli beginning teachers.	A year's induction yielded a moderately high satisfaction based upon variables such as mentor support, principal guidance, peer support, and decreased workload. Mentors and colleagues had the greatest impact on assimilation.
A qualitative study of mental health nurse identities: Many roles, one profession Hurley, J.	2009	24 interviews	Generic specialist; identity construction is personal—cannot be considered singular nor fixed, should be seen as a cluster of capabilities; external perspective of group identity can be negative.

*Becoming a nurse: A meta-study of early professional socialization and career choice in nursing Price, S.	2009	Various studies with analysis undertaken using Paterson et al.'s framework for qualitative meta-synthesis.	Three main themes were identified: influence of ideals; paradox of caring and role of others. Career choice and early professional socialization are influenced by: role of mentors, peers and role models in the formulation of career expectations, and career choice decisions.
Socialization in health education Arndt, J., King, S., Suter, E., Mazonde, J., Taylor, E., & Arthur, N.	2008	83 Canadian health and academic workers via individual and group interviews.	Respondents indicated that socialization prepares health care students for interprofessional environments by "building a professional identity" and through what we are labeling "interprofessional familiarization" (i.e., where the goal is to introduce students to the roles and function of other professionals outside their own discipline) (p. 18). "A strong professional identity is needed to work as a distinct entity within an inter-professional health care environment" (p. 20). "Inconsistencies in the socialization process may lead to greater barriers, consequently impacting the students' opportunity and ability to work interprofessionally. Canada places effort into socialization for those in public health, but largely rely on academia to build a professional identity because most employed in public health go through a similar program.
Professional identity in community mental health nursing: A thematic analysis Crawford, P., Brown, B., & Majomi, P.	2008	34 participants interviewed	Key Themes: (1) the client focus of this service profession; (2) not being a profession; (3) growing out of the role: professional development as exit strategy; (4) waiting to be discovered: search for recognition = invisibility of this service profession and thus lack of identity; "Identity-work." Jack of all trades diminish prof id development.
Belongingness: A prerequisite for nursing students' clinical learning Levett-Jones, T. & Lathlean, J.	2008	Mixed methods: 18 student nurses participated in interviews; 362 completed a survey.	"Feeling safe, comfortable, satisfied and happy were reported by many students to be outcomes of a placement that facilitated belongingness. In addition, belongingness was seen to be a phenomenon that was directly related to nursing students' self-concept, degree of self-efficacy, the extent to which they were willing to conform with poor practice, and their future career decisions" and "Students felt more empowered and enabled to capitalize on the available learning opportunities when they felt they had a legitimate place in the nursing team, and they were often more self-directed and independent in their approach" (p. 107). Those with whom they interacted with on a day-to-day basis had the most influence.
Newcomer adjustment during organizational socialization: A meta-analytic	2007	Literature Review: Chosen studies included newcomers 13 months or less	Role clarity, self-efficacy, and social acceptance are important indicators of newcomer adjustment Successful newcomer socialization leads to less turnover and intentions to leave; appraisal was the strongest predictor of newcomer adjustment; mentors are recommended

review of antecedents, outcomes, and methods Bauer, T. N., Bodner, T., Erdogan, B, & Truxillo, D. M.		resulting in 70 unique samples (N=12,279), the mean were longitudinal studies.	
Interlevel influences on the resoncstruction of professional role identity Chreim, S., Williams, B. E., & Hinings, C. R.	2007	74 Interviews of physicians, decisions makers	Reconstruction of professional identity is based largely on professional associations and government setting the scope of power and authority that can assist successful reconstruction for those in mid to late career. These individuals have different motivations and issues for those organizing socialization tactics to consider. Macro (organizational) vs. micro (individual).
Investigating the factors influencing professional identity of first-year health and social care students Adams, K., Hean, S., Sturgis, P., & Macleod Clark, J.	2006	1254 questionnaires by students from a variety of fields	Students had pretty strong professional identity upon program entry, more so if cognitive flexibility was strong, if there was previous work experience or understanding of team workings.
Public health at center stage: New roles, old props Beitsch, L. M., Brooks, R. G., Menachemi, N., & Libby, P. M.	2006	Using data from the 2005 ASTHO and NACCHO surveys to account for workforce infrastructure and financial support.	"The largest percentage of the public health budget is invested in its workforce" (p. 920). "Public health is not funded well enough to meet the demands and expectations of an aging population that is further threatened by terrorism and natural disasters" (p. 921). Calls for more public health research and funding for such; call for national public health system with named functions consistency

A state-based analysis of public health preparedness programs in the United States Beitsch, L. M., Kodolikar, S., Stephens, T., Shodell, D., Clawson, A., Menachemi, N., & Brooks, R. G.	2006	Using data from the 2005 ASTHO survey to assess organizational structure, administration, personnel, and resources.	"On average, 65.4 full time equivalents (FTE's) were added to LPHAs. A typical state public health preparedness program was strengthened by support of 42 positions" (p. 742). Good background of funding streams
Organizational structure and job satisfaction in public health nursing Campbell, S. L., Fowles, E. R., & Weber, B. J.	2004	192 participants from 19 county health departments in Illinois completed a survey.	Job satisfaction increases with: vertical and horizontal decision making opportunities increase; the number of years employed; joint decisions between supervisor and subordinates; if peers are involved in decision-making as part of organizational structure
Becoming professional: Exploring the complexities of professional socialization in health and social care Clouder, L.	2003	3-year longitudinal interviews of 12 health students.	Individual agency is important during socialization to improve and adapt to changing situations; collective generation of meaning; idea of not being tied to any one particular image or identity but certain essential traits exist (p. 216) "It is vital that newcomers begin to position themselves in relation to expectations" (p. 219); need for continued socialization like re-socialization by Clark 1994.
Beginning students' definition of nursing: An inductive framework of professional identity Cook, T. H., Gilmer, M. J., & Bess, C. J.	2003	109 student nurses using qualitative descriptive approach from asking 1 question: What	-professional identity is developed throughout career -early prof identity begins during education -early definitions didn't include ethics, culture, legal, and economic issues but showed a rudimentary conception of professional identity (aka preexisting perceptions)

		is your definition of nursing?	
Reworking professional nursing identity MacIntosh, J.	2003	21 nurses using grounded theory	3 stages of professional ID: assuming adequacy, realizing practice, and developing a reputation – “occur when nurses encounter discrepancies that stimulate feelings of dissonance and work to develop strategies to address those discrepancies and reduce the dissonance” (p. 730). “Three contextual factors influence the process: expectations, perceived status, and supportiveness” (p. 738). -professional identity is developed throughout career.
The effectiveness of an organizational-level orientation training program in the socialization of new hires Klein, H. J. & Weaver, N. A.	2000	116 employees from a variety of organizations were questioned at 1 and 2 months following an orientation.	Orientation, as a component of socialization, can be both formal and informal geared to both job and organization orienting. 4 foci or levels (the job, the work group, the organization, and one's trade or profession). Funding and hiring patterns often preclude offering orientations with the frequency needed for them to be timely for all new hires.
‘I don’t want to be a psychiatric nurse’: An exploration of factors inhibiting recruitment to psychiatric nursing in Ireland Wells, J. S. G., Ryan, D., & McElwee, C. N.	2000	56 students among 4 different focus groups	Poor self-concept and lack of skill confidence emerge from poor career guidance. “School students rely on stereotypical views as part of their decision making processes” (p. 86). Images promoting these careers were outdated and unappealing thus affecting recruitment.
Provisional selves: Experimenting with image and identity in professional adaptation Ibarra, H.	1999	Interviews and observations with 34 professionals (management or bankers)	3 tasks revealed for those orienting to new roles: (1) observing role models to identify potential identities, (2) experimenting with provisional selves, and (3) evaluating experiments against internal standards and external feedback (p. 764). External vs internal socialization; personal identity; identity matching to role models; informal socialization as a concept contrasting other studies whereby an employee develops their own role model and thus professional identity by taking pieces from various others “on the basis of personal experiment and feedback” (p. 783). Organizational characteristics such as the scarcity of women in top positions affects affect this type of professional identity development.
Socialization and newcomer	1998	223 self-reporting	Organizational context likely influences effectiveness of socialization; job design (aka task structure) affect socialization (5-character model); at 10 months, newcomers had more or less settled into their

adjustment: The role of organizational context Ashforth, B. E., Saks, A. M., & Lee, R. T.		newcomers after 4 and 10 months.	new jobs; "institutionalized socialization is likely to be seen as functional for large and mechanistic organizations, given their proclivity toward reproducing the status quo and exerting greater control over newcomers' attitudes and behavior" (p. 919). Therefore institutionalized socialization assists newcomer adjustment more than individualized socialization.
Professional identity: Values embedded in meaningful nursing practice Fagermoen, M. S.	1997	Mixed methods: 767 participant survey and 6 in-depth interviews	“A transcultural common core of nurses’ professional identity seems to be surfacing, namely, the actualization of the values of dignity, personhood, being a fellow human, and reciprocal trust, which depicts nursing as a human and moral practice concerned with providing personalized care to patients” (p. 439) “Nurses’ professional identity appears to evolve from a general altruistic motivation to a set of values which are specific and differentiated . . . and revisional” (p. 440).
Socialization tactics: Longitudinal effects on newcomer adjustment Ashforth, B. E. & Saks, A. M.	1996	Longitudinal (approximately 1 year) questionnaires for 295 college business graduates measuring the 6 Van Maanen & Schein socialization tactics.	Institutionalized socialization proved stronger newcomer conformity to an organization over individual socialization. Extends Van Maanen & Shein’s (1979) findings that institutionalized socialization produces less ambiguity, role conflict, stress, and higher job satisfaction. Wide variance in socialization trajectories across newcomers, occupations, and organizations [leads to] vagueness in time lines” (pp. 174-5).
Professional socialization and health education preparation Hayden, J.	1995	179 students assessed using Occupation Inventory (OI).	Professionalism and credentialing should co-exist as it make students more ready and thus more committed to workforce development ongoing; senior students were not shown to be more professionalized than freshman; Early courses lent more to professionalism than later academic career courses. Attributes such as prof membership.
Organizational socialization content and consequences	1994		6 content dimensions (politics, history, people, performance proficiency, language, and goals/values)

Chao, G. T., O'Leary-Kelly, A. M., Wolf, S., Klein, H. J., & Gardner, P. D.			
*Socialization tactics, self-efficacy, and newcomers' adjustments to organizations Jones, G. R.	1986	Longitudinal; 102 MBA Students completed 2 questionnaires.	"Newcomers are likely to have proclivities to interpret situations in certain ways and to respond to them in their own terms." This finding suggests that newcomers use self, as well as others, as a locus of control when evaluating situations (Weiss, 1978). The results suggest that newcomers high in self-efficacy will tend to define situations themselves even when their roles or progressions in organizations are prescribed" (p. 275). 4 hypotheses supported: Institutionalized socialization tactics produce custodial role orientations and individualized tactics will produce innovative role orientations. Institutionalized socialization tactics will be negatively related to role conflict, role ambiguity, and intention to quit, and positively related to job satisfaction and commitment. Investiture and serial methods will be the most important among the six categories of socialization tactics in mediating personal adjustments to organizations. A newcomer's level of self-efficacy will moderate the effects of institutionalized tactics on role orientation.
*The availability and helplessness of socialization practices Louis, M. R., Posner, B. Z., & Powell, G. N.	1983	217 business school alumni completed questionnaire during first year of employment.	"The three most important socialization aids were interaction with peers, supervisor, and, senior coworkers (p. 860); "Taken as a "set" of socialization practices, however, the "availability" of socialization opportunities was significantly associated with subsequent job attitudes" (p. 861). A wide variety of socialization practices were studied from social outings to business trips.
Nurse practitioners: Issues in professional socialization Lurie. E. E.	1981	Interviews and observations of nurse practitioners on 12 scales.	Education "is the most important determinant of role content" (p. 46). Professional employment is " the more powerful determinant of socialization" (p. 46) –is the more powerful socializing agent" (p. 46). Professionals "find themselves giving up some expectations of the professional role to which they were socialized [during education] in order to function as professional employees.
Student nurses' accounts of their	1981	40 interviews ethnography/ interpretive	Student nurses felt some apprehension and anxiety at the unexpected role of nursing once entering the profession. Nursing is a segmented occupation: education and service. 'Fitting in' and 'just passing through' are components of socialization with nursing.

work and training: A qualitative analysis Melia, K. M.			
From student to nurse: A longitudinal study of socialization Simpson, I. H.	1979	Longitudinal; 8 cohorts of nursing students followed through 4 years of academic and 1 year post-graduation.	“Findings argue that a view of socialization that defines it as a matter of learning or motivation is overly simple. Processes do not only develop individually; their development may require separation from other processes, or, conversely, integration with other processes” (p. 167). Socialization should not be viewed as a linear process with a beginning and end based upon what an individual learns. Simpson suggests rather looking at it as occupational recruitment. Simpson also suggests performing socialization in groups.
Becoming professional Bucher R. & Stelling, J. G.	1977	Longitudinal 3-interview study of 48 trainees in psychiatric, biochemistry, and internal medicine residency programs.	“Professional identity and commitment to a profession are so intricately intertwined as to be virtually inseparable”: commitment being to “both one’s work and one’s colleagues” (p. 215) but may be specific involving allegiance to only one particular subgroup or type of work within the field. “The data demonstrate that there is a “programming effect,” i.e., that the outcomes of socialization are, in large part, determined by the nature of the training program” (p. 257). “Among the situational variables, role-playing activities are of outstanding importance in the development of professional identity and commitment” (p. 266): role-modeling, coaching, and peer group relations are important but largely in supportive positions (p. 268). Yet “having a strong peer group can be very helpful to the individual trainee in traversing a difficult system” (p. 269). Trainees were often self-validating, using their own judgement on whether they were doing well or not.
A contingency theory of socialization Feldman, D. C.	1976	118 hospital employees interviewed and 47 Likert item questionnaire .	“Socialization programs may not be appropriate for achieving some of the results most frequently expected from them” (p. 449). General satisfaction of workers and autonomy are affected therefore less turnover. “Socialization processes. . .are correlated positively with indicators of the quality of the work environment rather than with the quality of the work itself” (p. 450).
Police socialization: A longitudinal examination of job attitudes in an urban police department	1975	136 new police recruits – 2 questionnaires.	Beginning of a general theory of organizational socialization via 4 stages: entry, introduction, encounter, and metamorphosis; Like Porter, Lawler, & Hackman (1975 book – not empirical) who call the Anticipatory Stage the Pre-Arrival Stage. The accommodation stage the encounter stage.

Van Maanen, J.			
Building organizational commitment: The socialization of managers in work organizations Buchanan, B.	1974	Questionnaire survey of 279 business and government managers.	Results consistent with other research: “years of organizational service, social interaction with organizational peers and superiors, job achievement, and hierarchical advancement” (p. 544) are related to organizational commitment. Description of 3 tenured stages of socialization: 1st year of employment; 2nd-4th year of employment; 5th year and beyond.
Professionalization and Bureaucratization Hall, R. H.	1968	328 workers from a variety of occupations.	“Professional import standards into the organization to which the organization must adjust” (p. 103). “increased bureaucratization and professionalization might lead to conflict in either the professional organization or department” (p. 103). “equilibrium may exist between the levels of professionalization and bureaucratization in the sense that a particular level of professionalization may require a certain level of bureaucratization to maintain social control” (p. 104).

APPENDIX C:

UWM Consent to Participate in Research

UNIVERSITY OF WISCONSIN – MILWAUKEE
CONSENT TO PARTICIPATE IN RESEARCH

1. General Information

Study title:
Understanding Public Health Professional Socialization and Professional Identity Formation Experiences

Person in Charge of Study (Principal Investigator):
Primary Investigator (PI), Dr. Barb Daley, Interim Associate Dean, Academic Affairs, College of Nursing, UWM
Student Primary Investigator (SPI), Jennifer Freiheit, UEDP doctoral student, UWM

2. Study Description

You are being asked to participate in a research study. Your participation is completely voluntary. You do not have to participate if you do not want to.

The purpose of this study is to explore the professional socialization and professional identity experiences of employees fairly new to the public health field. Little is known about how the public health workforce is socialized into their profession. This is important because vast numbers of public health employees are leaving the field and retiring without employees to take their place thus threatening the viability of local public health agencies and extends to the health of the population. Socialization processes serve a vital role to assuring employees are not only competent and prepared to do their jobs, but that they will remain in the field with higher levels of job satisfaction and performance. Organizational context can influence the socialization process. Both organizational context and professional socialization can aid in the formation of professional identity. Public Health leaders need to better understand how these factors are perceived to impact and retain public health professionals.

Ten to fifteen local public health employee subjects will be interviewed. Participants should have worked in public health for at least one full year but not more than seven years. Participants current position should be one in which they entered the field. Age, background, and gender identification does not matter.

3. Study Procedures

What will I be asked to do if I participate in the study?
If you agree to participate you will be asked to be interviewed once or twice at a location of your choosing (e.g. your office, conference room, library, coffee shop) with possible email or phone call follow-up for clarification purposes. Each interview will take between 90-120 minutes, over the course of 3 months. There may be additional time involved if you wish to review (member-check) my transcription of your interview. No preparation work is needed by participants prior to the interviews.

Audio recording will initially be used for transcription purposes by the researcher, ensuring accuracy of your words. Opting out of the audio recording does not preclude you from participating in this study.

4. Risks and Minimizing Risks

What risks will I face by participating in this study?
The potential risks for participating in this study are minimal – no greater than what you would experience in your everyday life.

Psychological: It is possible that talking with the researcher will stir up some emotions, bring up difficult memories, or cause you to feel embarrassed about your experiences. If you are asked a question you do not want to answer, you don't have to answer that question. If distressed, the researcher will ask if you would like to skip a question and move on, stop for the day and schedule to finish later, or completely stop the research.

5. Benefits

Will I receive any benefit from my participation in this study?
Although you will not receive any personal benefits from participating in the research, you will have the satisfaction of knowing that you have contributed to the betterment of public health through understanding of socialization and professional identity efforts in the field. The benefits of the project should be greater than any risks.

6. Study Costs and Compensation

Will I be charged anything for participating in this study?
You will not be responsible for any of the costs from taking part in this research study.

Are subjects paid or given anything for being in the study?
You will not be compensated for taking part in this research study.

Your agency may benefit from counting your time and participation as work toward Public Health Accreditation Board (PHAB) Standard 10.2. However, the researcher nor the university

will ever confirm or discuss your participation with your Health Officer, supervisor, agency, city, or anyone else in order to protect your confidentiality. Your agency will only know if you participated if you share the information. You should feel no pressure to share your participation or any information you will have shared with the researcher.

Conflict of Interest Disclosure: The researcher has and is currently doing independent consulting work with a couple of the municipalities to which a participant may or may not come from.

7. Confidentiality

What happens to the information collected?
All information collected about you during the course of this study will be kept confidential to the extent permitted by law. I may decide to present what I find to others, or publish the results in scientific journals or at scientific conferences. Information that identifies you personally will *not* be released without your written permission. Only the researchers named above will have access to the information. However, the Institutional Review Board at UW-Milwaukee or appropriate federal agencies like the Office for Human Research Protections may review this study's records.

Privacy: Your likeness will be used but with a de-identified pseudonym that will not state your name, your employer or agency, nor your municipality. For example, the pseudonym entered upon transcription may read **'**John from suburban Broadville Health Department in a Midwestern metropolitan area." There is little risk of a privacy breach as the data will only be analyzed and stored on the student principal investigator's password-protected computer. All study results will be reported without identifying information so that no one viewing the results will ever be able to match you with your responses. Direct quotes may be used in publications or presentations.

All interview notes, transcriptions, contact information, and audio files will be stored on the researcher's password protected computer for five years after any final publication, at which time all files will be erased.

8. Alternatives

Are there alternatives to participating in the study?
There are no known alternatives available to you other than not taking part in this study.

9. Voluntary Participation and Withdrawal

What happens if I decide not to be in this study?
Your participation in this study is entirely voluntary. You may choose not to take part in this study. If you decide to take part, you can change your mind later and withdraw from the study.

You are free to not answer any questions or withdraw at any time. Your decision will not change any present or future relationships with the University of Wisconsin Milwaukee.

If you withdraw early, the information collected to that point will be used, unless you request that it not be used.

10. Questions

Who do I contact for questions about this study?
For more information about the study or the study procedures or treatments, or to withdraw from the study, contact:

Jennifer Freiheit
Department of Administrative Leadership, Urban Education Doctoral Program (UEDP), School of Education, University of Wisconsin-Milwaukee

OR

Barbara J. Daley, PhD, RN
Interim Associate Dean for Academic Affairs, College of Nursing
Professor, Adult and Continuing Education Program, Department of Administrative Leadership, School of Education
University of Wisconsin - Milwaukee
PO Box 413
Milwaukee, WI 53201
414-229-5098
bdaley@uwm.edu

Who do I contact for questions about my rights or complaints towards my treatment as a research subject?
The Institutional Review Board may ask your name, but all complaints are kept in confidence. Reference IRB#: 17.283 approved April 5, 2017.

Institutional Review Board
Human Research Protection Program
Department of University Safety and Assurances
University of Wisconsin – Milwaukee
P.O. Box 413
Milwaukee, WI 53201
(414) 229-3173

11. Signatures

Research Subject’s Consent to Participate in Research:

To voluntarily agree to take part in this study, you must sign on the line below. If you choose to take part in this study, you may withdraw at any time. You are not giving up any of your legal rights by signing this form. Your signature below indicates that you have read or had read to you this entire consent form, including the risks and benefits, and have had all of your questions answered, and that you are 18 years of age or older.

____
Printed Name of Subject/ Legally Authorized Representative

____ ____________________
Signature of Subject/Legally Authorized Representative Date

Research Subject's Consent to Audio Recording:

It is okay to audio record me while I am in this study and use my audio data in the research.

Please initial: ____Yes ____No

Principal Investigator (or Designee)
I have given this research subject information on the study that is accurate and sufficient for the subject to fully understand the nature, risks and benefits of the study.

____ ____________________
Printed Name of Person Obtaining Consent Study Role

____ ____________________
Signature of Person Obtaining Consent Date

APPENDIX D:

Individual Interview Protocol

Interview Questions

PURPOSE OF INTERVIEW: To elicit preliminary information and uncover meanings from participants' experiences in socialization; and to garner trust. Then to obtain clarification and further get into the inner voice or essence of the research questions

RELATION TO RESEARCH QUESTIONS: This first half of the interview sought to completely answer research question 1: How do urban public health employees experience the professional socialization process within their profession? And begin to address research question 2: How do the organizational contexts elicit or diminish professional socialization processes in the field of public health? The second half of the interview dove into the more philosophical concepts that relate to professional identity and research question 3: What influence does the professional socialization process have on the formation of a public health professional identity? And will further gather information for research question 2: How do the organizational contexts elicit or diminish professional socialization processes in the field of public health?

Interview Questions

Demographics *(all OC)*

- Job Title:
- Age and Gender:
- *[SOC]* What was your background/schooling? [Was it more specific or general?]
  - How did it prepare you for the field?
- Years/Months in public health field:

- Is public health your first career?
- Size of Agency (# of employees):
- Tell me about your current role. [autonomy; spec vs gen task identity, skill variety, and task significance]
    - Is this the role you entered your public health career in?
- Are you a supervisor?
- Tell me about your supervisor. [job feedback]

Prior to Career

- *[ID]* Tell me about why you chose or how you landed in the public health field?
    - Was there a particular event or trigger point that aided your decision?
- *[ID]* Think back to before you got the job and what you imagined a career in public health would be like. What did you expect your job to be like before you started in public health?
- *[SOC]* Remember how you felt as a new employee. Tell me about those first few days or weeks.
    - [Note feelings about career versus organization.] Did those feelings change by the end of that first year?
    - In what ways were your prior expectations confirmed? Disconfirmed?
    - *[ID]* How has your image of public health changed since entering (if at all)?
- *[ID]* How strongly do you identify with public health culture? To what degree do your moral beliefs and values align with public health?

Early Training

- *[SOC]* Think of how you felt in that first year. What helped you during your first year of this career to come into your role?

- Describe any induction, orientation, socialization, on-the-job training? [Look for whether a program was structured. Look for how well supervisors were trained to orient new employees.]
  - How many days/hours?
  - What did you learn? (Maybe ask for one example if proving difficult to answer).
  - *[ID]* Did these activities make you feel a part of the profession? How so?
  - Tell me about any difficulties in learning the public health "blueprints for behavior" (rules/jargon/rhythms/demands/etiquette/rituals).
  - *[OC]* Tell me about any early feedback you may have received.
  - Did you have to be proactive in seeking your own information? Or were things lined up for you to learn?
  - Tell me about how you were taught to react to external forces (i.e. community, government/political system, grants/economic/tax levy) Were you taught to handle internal issues differently? (Schein, 1990, p. 111)
- *[SOC]* Are there continuing education opportunities?
  - Did they start in year one? Do they continue today?
  - Do you receive licensure credits for taking such courses?
  - Is the continuing education directly related and integrated into your practice?
- *[SOC]* Aside from money and time resources (even if these are issues), what support do you feel is ideally needed to begin a public health career? (not just training needs)

Psychosocial Support

- *[SOC]* Tell me about any mentoring relationships since your arrival in the public health field.
    - If ***yes***, has this relationship provided you with:
        - counseling or friendship support related to personal development?
        - career assistance/advancement such as coaching?
        - role modeling?
    - How was the relationship initiated (by you or the mentor)?
    - Or if ***no*** relationship, do you think it would be helpful? If yes, how so? How might you find a mentor and initiate a relationship?
    - Is there a formal mentorship program in your agency? Does the agency provide training on mentoring?
- *[SOC]* Have you found a network of peers that you can trust? Tell me about this group.
- *[SOC]* Tell me about any other methods of induction support you have experienced or participated in: learning circles, support groups, communities of practice, reflective writing, observation, conference attendance, readings, and modeling?
- *[SOC]* Were there social networking opportunities?
- *[SOC]* What methods left you feeling empowered and supported to do your work?
- *[SOC]* What was it like trying to get accepted by other public health workforce members?

- *[SOC]* Do you desire to become a mentor in the public health field?

Philosophical/Future

- *[SOC]* Were you mentored by a person that worked in public health prior to 9/11? How did this help or hinder your learning?
- *[SOC]* Were you trained by a person that worked in public health prior to 9/11? How did this help or hinder your learning?
- *[ID]* How has your public health career melded into/transferred into your personal life? (e.g. sense of self, belief, values?)
- *[SOC]* What are the keys to your success in this field?
- *[ID]* Name a few things about the job that provide a sense of satisfaction or are important.
- *[OC]* How much opportunity do you have to influence the way things are done around your department?
    - If you had an idea about improving the ways jobs are done around here, how likely do you think it is you could change something?
- *[ID]* *Do you think you have passed from being an outsider to an inside member of the public health profession? If so, at what point? (i.e. during schooling, upon entering, later?)
    - How are you part of the public health profession?
- *[ID]* Describe your public health professional identity.
    - If you were certified in public health through a national program, would that help to garner a stronger public health professional identity?

- *[ID]* Would you say you ally yourself more with the profession of public health *or* just this workplace and workforce?
- *[ID]* Where do you see yourself 5 years from now?
    - How optimistic are you about your future in public health?
- *[SOC]* Think of three of your closest colleagues (I do not need their names). What would they say to describe you? Your professional identity?
    - Do you agree with their assessment? Why or why not?
    - Is this how they would have described you during your first year in public health?
- *[ID]* What is it going to take to recruit and retain talent to the public health field? (Look for ideas such as marketing and work with MPH programs, but don't lead them with these ideas.)
- Had you thought about or reflected on your professional socialization prior to this interview?

CURRICULUM VITAE

Jennifer Freiheit, PhD, MCHES

EDUCATION

PhD, **Urban Education Doctoral Program** *9/09 – 12/17*
Department: **Administrative Leadership**
Specialization: **Adult, Continuing, & Higher Education Leadership**
Minor: **Public Health**
University of Wisconsin-Milwaukee – Milwaukee, WI
Dissertation: *Understanding Public Health Professional Socialization and Professional Identity Formation Experiences*

MA**, Wellness Management & Gerontology** *8/00 – 7/02*
Minor: **Business Administration**
Ball State University – Muncie, IN

BS, **Health Education,** Cum Laude Honors *8/97 – 5/00*
Minors: **Anthropology, Political Science**
Illinois State University – Normal, IL

PROFESSIONAL EXPERIENCE

Public Health Consulting

Bay View Advanced Management, LLC, sole proprietor *8/08 – Present*

- Develop online workforce assessments and subsequent workforce development plans based upon various competency sets
- Educate and train local public health agency leaders and staff and local government leaders in all aspects of emergency preparedness and response
- Facilitate focus groups in community health topics of concern for Community Health Assessments (CHA) and strategic planning efforts
- Write city-wide and department-specific operational emergency response plans, Incident Command structures, Community Health Improvement Plans (CHIP), and local public health agency Strategic Three Year Plans
- Lead accreditation efforts including regional Project Public Health Ready (PPHR) and various objectives for continuous quality improvement for the Public Health Accreditation Board (PHAB)
- Conduct exercises compliant with Homeland Security Exercise and Evaluation Program (HSEEP)
- Develop and train on media communication toolkits

Academic

Graduate Assistant, Department of Administrative Leadership *06/11 – 05/14*
University of Wisconsin-Milwaukee

- Developed D2L Online courses, syllabi, and lesson videos
- Edited empirical research including proofing, APA citation, and publication readiness
- Website development using Dreamweaver for professor's personal pages and assisted with redesign of university program external and internal web pages
- Developed, disseminated, collected, and assembled all departmental course evaluations using Qualtrics software
- Grant writing and applications assistance

Public Health Practice

Regional Program Coordinator *10/03 – 06/11*

Milwaukee/Waukesha County Consortium for Emergency Public Health Preparedness
Milwaukee and Waukesha Counties, WI

- Led Centers for Disease Control and Prevention (CDC) and Wisconsin Division of Public Health (DPH) annual grant objectives for fourteen local public health agencies within two counties
- Identified resources and facilitated trainings (using various technologies and learned education techniques), volunteer/expert recruitment, contract work, and facilitate workforce development to support consortium-member growth
- Formed strategic alliances with external partners including federal, state, local, corporate, academic, and not-for-profit partners to develop integrated response and crisis communication plans
- Achieved year-long national accreditation project for all fourteen agencies in a regional application
- Facilitated numerous integrated and cross-functional subgroup and subcommittee efforts in a collaborative environment to achieve overall mission and goals and grant objectives including Board of Directors

Education and Training Coordinator, Public Health Preparedness *12/02 – 10/03*

Wisconsin Department of Health and Family Service, Division of Public Health, Chronic Disease Section
Madison, WI

- Designed course content, developed videos, marketed, and coordinated evaluations for a ten module public health infrastructure online course including topics of Media Communication and Isolation and Quarantine known as the Public Health Emergency Training (PHET)
- Educated local public health agency staff on statewide public health emergency and disaster education and strategic planning
- Collaborated on educational efforts with the University of Minnesota Center for Public Health Preparedness
- Identified appropriate public health education materials, strategies, and methodologies that addressed emergency preparedness for workforce development

PUBLICATIONS

Harrison, K. L., Errett, N. A., Rutkow, L., Thompson, C. B., Anderson, M. K., Ferrell, J. L., Freiheit, J. M., Hudson, R., Koch, M. M., McKee, M., Mejia-Echeverry, A., Spitzer, J. B., Storey, D., & Barnett, D. J. (2014). An intervention for enhancing public health crisis response willingness among local health department workers: A qualitative programmatic analysis. *American Journal of Disaster Medicine, 9*(2), 87-96. doi: http://dx.doi.org/10.5055/ajdm.2014.0145 retrieved from http://www.wmpllc.org/ojs-2.4.2/index.php/ajdm/article/view/91

Barnett, D. J., Thompson, C. B., Semon, N. L., Errett, N. A., Harrison, K. L., Anderson, M. K., Ferrell, J. L., Freiheit, J. M., Hudson, R., McKee, M., Mejia-Echeverry, A., Spitzer, J., Balicer, R. D., Links, J. M., & Storey, J. D. (2014). EPPM and willingness to respond: The role of risk and efficacy communication in strengthening public health emergency response systems. *Health Communication, 29*(6). doi: 10.1080/10410236.2013.785474 retrieved from http://www.tandfonline.com/doi/abs/10.1080/10410236.2013.785474#.Ui886tLkvE0

Barnett, D. J., Thompson, C. B., Errett, N. A., Semon, N. L., Anderson, M. K., Ferrell, J. L., Freiheit, J. M., Hudson, R., Koch, M. M., McKee, M., Mejia-Echeverry, A., Spitzer, J., Balicer, R. D., & Links, J. M. (2012). Determinants of emergency response willingness in the local public health workforce by jurisdictional and scenario patterns: A cross-sectional survey. *BMC Public Health, 12*(164). doi: 10.1186/1471-2458-12-164 retrieved from http://www.biomedcentral.com/1471-2458/12/164

Stohler, J. (2002). Award-winning marketing. *Journal on Active Aging, 4*, 29-31.

CONFERENCE PROCEEDINGS AND REPORTS

Murphy, D. D., & Freiheit, J. M. (2013, January). The development and validation of the mentoring expectations congruency scale (MECS). In *Academy of Management Proceedings* (Vol. 2013, No. 1, p. 14555). Academy of Management.

Freiheit, J. M. (2012). *Assessment of a Milwaukee Health Department leadership program: Emotional Intelligence training, 360° assessments, and professional coaching.* Non-Proprietary Technical Research Report submitted to the City of Milwaukee Health Department.

PUBLICATIONS IN PROCESS

Murphy, D. D., & Freiheit, J. M. The Development and Validation of the Mentoring Expectations Congruency Scale (MECS). Intent to be submitted to Journal of Applied Psychology January 2018.

Freiheit, J. M. Public Health Professional Socialization Experiences and Their Influence on Professional Identity Formation. Intent to be submitted to American Journal of Public Health February 2018.

Freiheit, J. M. Defining a Professional Socialization Program for New Public Health Employees: Focus and Timeline. Intent to be submitted to Journal of Public Health Management and Practice February 2018.

Freiheit, J. M. & Daley, B. Public Health Professional Socialization and Professional Identity: An Integrative Literature Review. Intent to be submitted to Journal of Public Health Management and Practice March 2018.

ACADEMIC CONFERENCE PRESENTATIONS

Murphy, D. D., & Freiheit, J. M. (August 2013). The Development and Validation of the Mentoring Expectations Congruency Scale (MECS). Academy of Management Conference, Orlando, Florida. *(refereed)* **The Arnon Reichers Best Student Paper Award Finalist**

Freiheit, J. M. (November 2012). Baptism by fire: A qualitative study on public health employee orientation experiences. American Association for Adult and Continuing Education Conference, Las Vegas, Nevada. *(refereed)*

PROFESSIONAL PRESENTATIONS (abbreviated list)

Methods for Regional Collaboration: NPHPSP, MAPP, Operational Definition and PPHR *10/08*
American Public Health Association (APHA) Annual Meeting San Diego, CA

Strategies for Innovative Training Methods *02/07 & 02/08*
National Association of City and County Health Officials (NACCHO) Annual Conference
Washington DC & Atlanta, GA

Pandemic Preparedness Symposium for Business by the Wisconsin Council of Safety *10/06*
Oconomowoc, WI
Keynote address to region-wide business and community partners emphasizing the need to communicate with local public health, providing a framework for a communications strategy, and helping identify planning partners while educating about pandemic influenza

Southeastern Wisconsin Pandemic Influenza Preparedness Community *8/06*
Partner Forum sponsored by Medical College of Wisconsin Milwaukee, WI
Coordinated and moderated day-long forum on pandemic influenza preparedness

TEACHING & INSTRUCTION EXPERIENCE

Online and Face-to-Face Seminars and Workshops in Public Health Profession *2002 – Present*
Substitute Teacher, all grade levels, Muncie, IN *2000 – 2002*
Illinois State University (ISU) Woman's Reproductive Health Class *1/00 – 5/00*
Student Teaching, Clinton High School *2000*
Illinois State University Peer Education *6/99 – 5/00*
Red Cross HIV/AIDS certified instructor *2/98*

LEADERSHIP INSTITUTES

Future Milwaukee sponsored by Marquette University *2006 – 2007*
Milwaukee's oldest and most active community leadership development program
Mid-America Regional Public Health Leadership Institute *2004 – 2005*
Fellowship Program Graduate
Illinois Advanced Executive Public Health Leadership Institute *2004 – 2005*
Fellowship Program Graduate, University of Illinois at Chicago, School of Public Health

WORKGROUP, COMMITTEE, & SERVICE ACTIVITIES

Core Competencies for Public Health Professionals Workgroup *May 2017 on*
(Council on Linkages) Public Health Foundation
National Association of County and City Health Officials (NACCHO) *2016 – 2017*
Project Public Health Ready (PPHR) Regional Model Workgroup
Wisconsin Public Health Association (WPHA), Member *2014 – on*
Webinar Panelist, Commission for Workforce & Professional Development (CWPD) *August 2013*
Best Practices in Onboarding, Theoretical Basis for Onboarding

American Association for Adult & Continuing Education (AAACE) *2012 – 2014*
Member of Commission for Workforce and Professional Development (CWPD) Committee
Volunteer Peer-Reviewer, Commission for Workforce and Professional Development (CWPD) proposals for American Association for Adult & Continuing Education (AAACE) November 2012 conference *June 2012*
National Public Health Preparedness & Response Core Competency Model, Planning and Improvement Workgroup, Atlanta, GA **(ASPH)** *2010 – 2012*
National Association of County and City Health Officials (NACCHO) *2009 – 2011*
Preparedness Committee
State of Wisconsin Public Health Preparedness Advisory Committee *2007 – 2010*

AWARDS & CERTIFICATIONS

James C. Fisher Adult Education Fund, UWM School of Education (SOE) *09/17-12/17*
Kuehneisen and Eiserlo Scholarship, UWM School of Education (SOE) *09/13 – 05/14*
AAACE Conference Scholarship *11/12*
Master Certified Health Education Specialist (MCHES) *03/11 – Present*
Community Health Education Memorial Scholarship, WALHDAB *8/11 – 5/13*
Russell D. Robinson Adult Education Fellowship, UWM SOE 9/09 & *8/11*
Certified Health Education Specialist (CHES) *5/01 – Present*
Ann E. Nolte Scholarship, Illinois State University (ISU) *4/00*
Certified Health Education Specialist (CHES) Award, ISU *4/00*
Outstanding Achievement in Leadership and Scholarship Award, ISU *4/98 – 4/00*